The Bristol Medico-Chirurgical Journal.

"Scire est nescire, nisi id me
Scire alius sciret."

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THE EVOLUTION OF GYNÆCOLOGY.

The Presidential Address, delivered on October 14th, 1914, at the opening of the Forty-first Session of the Bristol Medico-Chirurgical Society.

BY

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IT is very difficult to express in words my appreciation of the honour conferred on me by this distinguished Society in selecting me as its President for the coming year. I know what a high record my predecessors have established, and in thanking you for the honour you have done me, I can only say I will try to do the best I possibly can for you.

Now one of my duties is to give you an opening address on the first day of the session, and I could wish it were possible for me to take a subject outside the profession; but unfortunately that is beyond my powers, and therefore I am driven to my own particular line, and I propose to give you quite a short paper on the evolution of gynæcology,

an essay which I fear will be dry as dust to the majority of my unfortunate listeners.

In no department, I suppose, has the progress been greater in medicine than in that assigned to the diseases of women.

Fifty years ago there was a craze for inflammation and ulceration of the os uteri, when every woman in a household was supposed to be a sufferer, and was treated accordingly.

There was a very short period when clitoridectomy was strongly advocated, only to be abandoned. Every backache, pelvic discomfort, or general neurosis was attributed to a mechanical displacement, and had to be treated by uterine pessaries.

There also came a time when oöphorectomy was advised for restraining hemorrhage from bleeding fibroids, and also for various neurotic symptoms, until the dire results produced by these operations were found out.

It is always a pleasure to acknowledge the debt of gratitude we owe to Lord Lister, for without his scientific discoveries the success of modern pelvic surgery could never have taken place.

In 1845 H. J. Bennett wrote a book insisting, amongst other things, " that inflammation is the chief factor, and that displacements and ulcerations follow from it, that this inflammation is confined to the cervical canal, and does not affect the body of the uterus, and that the disease should be attacked by strong caustics."

Only sixty years ago Velpeau in France and Graily Hewitt in our own country stood out as champions of the theory that all uterine trouble was caused by some malposition of the organ, and so every gynæcologist felt bound to invent some new form of cradle or pessary, or to modify some existing form, so that, to quote the words of Clifford Allbutt, " the uterus could justly proclaim that it was

always being impaled on a stem or perched on a twig," but there was no monotony about the twig.

While the current of gynæcology, as it has flowed down to us in an ever-widening stream from the past, is traceable largely to the Greeks, there is also evidence that it did not have its origin here, for the Greeks themselves wrote of the skill and learning of the physicians of Egypt.

The destruction of the Alexandrian Library has left the writings of Hippocrates, about 450 B.C., the oldest record containing anything like a systematic consideration of the diseases of women. He advised the use of aromatic fumigations in amenorrhea. May this be compared to the more modern suggestion of steaming the uterus? The woman who did not conceive was wrapped in blankets and fumigated from beneath. If the scent passed through her nostrils and her mouth, then it was known that she was not unfruitful. He also maintained that movement of the womb towards the head caused pain under the eyes and nose, with abundant frothy saliva; if it moved towards the hypochondrium it caused vomiting; if towards the liver, loss of speech and a livid skin. His knowledge of the sympathy between the uterus and mammæ is apparent, as he advises a large cupping instrument to the breast for uterine hemorrhage. The prolapsed uterus should be well washed with astringent lotions, restored to its place, and the woman placed on her back with the legs crossed and tied together. His description of cancer of the uterus is clear, and his prognosis is very gloomy.

Enough has been preserved of the writings of Galen and Celsus to show us that the speculum was not unknown, and that ulceration of the womb and leucorrhea in its several varieties had been recognised. In the excavations of Pompeii were found two specula which were probably

in common use at the time, and had been buried for nearly eighteen hundred years.

In the old writings of Aëtius the description given of the methods for preventing the legitimate consequences of sexual congress and for inducing abortion proves that the nefarious practices by means of which the females of our day would accomplish the same result are not of modern origin.

That four volumes of Aëtius were devoted to diseases of women is a revelation to those who suppose that gynæcology is a development of later times.

The relief of stenosis by means of sponge tents makes one think that the modern discoverer of this treatment derived his idea from Aëtius, or else it is a wonderful coincidence. Except for a few references by various writers, the speculum was a lost instrument for a thousand years until its rediscovery (if such it really was) by Récamier in 1816.

In 1852 Marion Sims made surgery of the vagina and uterus a more exact science. His invention of the position of the body in which the speculum was used was what the printing press is to civilisation, the compass to the mariner, steam to navigation, the telescope to astronomy, and here it was grander because it was the work of one man. He used first of all a bent spoon handle, and finding this so efficacious directly the air rushed into the vagina, thus opening up a region that had never been properly inspected before. Directly after manufacturing the speculum he proceeded to operate on a very bad case of vesico-vaginal fistula, produced by himself with the use of forceps in a long-delayed confinement. The operation failed again and again, until at last he hit upon the device of using silver wire for his sutures, and this was crowned with success.

In 1830 Hodge first invented his celebrated pessary, the idea being evolved out of his brain one night while looking

into the fire and noticing the supporting curve of a steel hook for supporting the shovel and tongs.

In 1876 at the American Gynæcological Society it was laid down as follows :—

1. Gonorrhœa persists for life in the male notwithstanding its apparent cure.

2. Latent gonorrhæa may exist in the male.

3. Latent gonorrhœa in the male may easily infect a perfectly healthy person.

4. Ninety per cent. of sterile women are married to men who have suffered from gonorrhœa previously or during their married life.

In my own personal experience a man having a supposed cure of gonorrhœa six years previously to marriage, and having no connection at all during that six years, infected his wife on the first night of his marriage, and also again developed the disease himself. Both were examined before marriage and passed as perfectly healthy, and were known to me for some years.

The ravages of gonorrhœa in a woman are hardly recognised, and the ordinary treatment of it is contemptible. Yet the virus of this disease gives rise to a group of pathological symptoms which surpass in importance any other class of affections with which the gynæcologist is called upon to deal. If gonorrhœa stood alone among the diseases of women that had been neglected for generations by the surgeons the explanation might be difficult ; but it has only shared what was the common lot with abdominal and uterine surgery, until the latter was removed from neglected subjects by the work of the specialists.

A French writer on venereal disease states that it is possible to cure a gonorrhœa so effectually that a man may safely get married forty-eight hours after an injection of

nitrate of silver. This is surgery fit only for satyrs, and yet the practical outcome of such advice and treatment is the ruin of the health of innocent women.

There can be no possible doubt that a large number of the apparently puerperal septic cases are of gonorrhœal origin. It is also quite possible for these symptoms not to appear for fully a month after the birth of the child, and unfortunately such cases have occurred in my own personal experience, where there cannot be the shadow of a doubt about the diagnosis.

The danger of gonorrhœa in the woman lies in this fact; the infection from the vulva, vagina or urethra may extend to the mucous membrane of the uterus, thence to the tubes, ovaries and peritoneum, and so may end in acute peritonitis from the escape of pus in the Fallopian tubes into the peritoneal cavity.

If you attach any value to statistics some are interesting reading. For example, out of one thousand men questioned eight hundred had at some time or other of their lives suffered from gonorrhœa, and at least one man put it down to making water in the night air. Out of one hundred women who married men who had at some time been afflicted with gonorrhœa only ten remained healthy as regards their sexual organs.

Gonorrhœal infection in women gives rise to a group of diseases which, by reason of their clinical interest and their social and moral consequences, surpass in importance every other class of affections which claim the attention of the gynæcologist, who, if he fails to closely examine into this subject, repulsive though it may be apart from its scientific interest, must constantly fail in his duty to his patients. Gonorrhœa is the most wide-spread of all the infectious diseases with the exception of measles, and the disease is one of the most common causes of sterility.

There can be no question that it is one of the most frequent causes of a declining birth-rate, for it cripples an endless number of men, and renders legions of women sterile. It is highly probable that over 50 per cent. of the inflammatory pelvic troubles met with in young married women are due to gonococcal infection by the husband, who is ignorant of the fact that he has not been cured before marriage of some early indiscretion.

It is a disgrace to our profession that so many men are told they are fit to marry after an attack of gonorrhœa without being properly examined. It is forgotten that the gonococcus may lie unsuspected in the ducts and glands that surround the urethra in the male.

Syphilis is a relatively harmless disease. It may cause discomfort, distress and even much pain, but does it ever kill a woman? If it does, where syphilis kills its tens gonorrhœa kills its thousands, and it would take the sufferings of a hundred cases of syphilis to make up for the long, weary years of agony of one case of gonorrhœal pyo-salpinx.

It is possible for there to be a complete absence of vaginal inflammation, for the gonorrhœa may be communicated directly to the uterus itself, and so may arise a case of acute pyo-salpinx. Where it goes straight through the tubes to the peritoneal cavity we may never get the initial story of vaginal infection.

A typical history is such as this: A woman, aged 30, beginning her menstruation at 14 years of age, is perfectly well up to 22, when she marries. A few weeks or months afterwards she has an ill-defined illness, which keeps her in bed for two or three weeks. She is told it is an attack of inflammation of the bowels, and though this subsides and she gets about again, she is never really well, always more or less an invalid and sterile! The ova are hindered from leaving the organ which is their source, and consequently

the impregnation by the male element becomes an impossibility.

Lawson Tait recorded many cases in which healthy women within a few days of marriage get a gonorrhœal perimetritis. One instance he gives that is particularly interesting: "A man loses his first wife with gonorrhœal septicæmia after her first parturition in the first twelve months; he marries again several years later, infects his second wife within a week of marriage, and has a recurrence himself." A case like this is absolutely conclusive of the harm that may be done by a latent gonorrhœa, unless both man and woman are telling most abominable falsehoods, and there is no reason to suspect them, as the man admits gonorrhœa seven years previous to his first marriage, and the second wife was a perfectly healthy woman of thirty years of age.

It is most distressing to have to believe that men will inflict the sufferings of gonorrhœa upon their wives within a few days of their puerperal trials. But however much we may deplore it, it has to be stated as a fact upon which there can be no dispute that we have the most serious complications arising directly from this cause in the majority of instances, and cases have actually come under my own observation. When we get the confession of a husband having conferred a gonorrhœa upon his wife, we are at once taken out of the category of frivolous anecdotes into the realms of fact.

I am quite convinced that a large number of puerperal deaths, which without due consideration are put down to puerperal fever, are usually caused by gonorrhœa.

In one year at Queen Charlotte's Hospital there were five deaths from puerperal fever so-called, and four of these had pyo-salpinx. Was not this due to the same source?

A man tells you he does not attach much importance to his discharge, so he gives it to his wife.

The evolution of abdominal surgery has proceeded entirely from the necessities of the special diseases of women, and the combination is so complete that it is unlikely it will ever again be separated.

In 1809 the first ovariotomy was recorded; it was successful, and the patient lived on for thirty-two years. The history of successful ovariotomy dates from the publication of Spencer Wells's book in 1864, and from this time onwards step by step we have reached our present success. At a very early period he did not allow anyone present who had been in contact with a septic case, and he kept his ward for abdominal surgery quite separated from sloughing septic cases, and he gave up all *post-mortem* work.

I saw my first ovariotomy at the age of fifteen. The operator did not even wash his hands or take off his coat, the instruments were placed on a blanket thrown over the patient's feet, the operation was done in twenty minutes, the pedicle was clamped outside the abdomen, and the clamp left on under a water dressing. On the third day after the operation I saw the case in the *post-mortem* room, with a large amount of stinking pus in the pelvis, and the man who made the *post-mortem* had three cases of puerperal fever in his own private practice, all of which were fatal during the following week. My first six cases seen in London later on all died; and the first case I had anything to do with in Bristol, in spite of many precautions, such as spraying the operation room for twenty-four hours previously, keeping all students out of the room, was fatal from septic purulent peritonitis. Now one may truthfully say that the percentage of deaths after operation for ovarian disease is practically *nil*.

In 1759 and 1791 cases are recorded in America of successful operation for ectopic pregnancy, and during the

sixteenth century several cases are mentioned, but in such a vague manner that their exact nature cannot be determined; in 1614 a *post-mortem* is recorded of a ruptured two-months' ectopic pregnancy, in which it is actually mentioned that the tube was much enlarged and ruptured; but it remained for Lawson Tait to really introduce the successful operation. In 1881 he was simply staggered at the suggestion of the general practitioner who called him in that he should open the abdomen, but two years later he successfully did the operation on another case. Ectopic pregnancy is an accident which may happen to any wife in the most useful period of her existence. It was first reported by Albucasis in the eleventh century, and yet until 1882 life was allowed to ebb away without a hand being raised to help the woman. Now the idea is to ligature the tube at once, and then remove the clots and debris at leisure. It may also be taken for granted that any intra-peritoneal hæmatocele is in all probability due to an ectopic gestation.

In the first case I saw personally the woman was enormously shocked and obviously suffering from some internal hemorrhage. On opening the abdomen some of the blood was let out, but no real search was made for the source of the trouble, and the wound was sewn up, the woman naturally dying the same night. On discussing this and other cases with the late Mr. Coe, he told me he had never in all his experience ever seen a case of ectopic pregnancy, and really tried to throw a damper on my youthful enthusiasm for operating, as he called it.

It now naturally falls to the lot of the gynæcologist to do very many hysterectomies or myomectomies for fibroid tumour, but until we were rendered safe by the wonderful discoveries of Lister and Pasteur, these operations were absolutely unsafe. At one time these tumours were left alone, with the hope (proved to be utterly fallacious) that they would

disappear at the menopause; or else they were removed by an operation in which the pedicle was fixed in the abdominal incision by the aid of the serre-nœud clamp, and in many cases suppuration took place at this spot. The one persistent and universal characteristic of all perfected surgical procedures is simplicity, so now the ordinary supra-vaginal or sub-total hysterectomy holds the field for most of these operations. It must, of course, only be undertaken by a man who has had the chance of gaining adequate experience and practice, for no operation can be more fatal than this in the hands of an amateur, and death almost invariably follows within a week when proper precautions are not taken during the operation. It is well to remember Keith's words: "It is unfortunately a melancholy story that ever since surgery began the most of the mischief was done by the surgeon himself. It was the willing and tender, though unclean, hand that carried the poison into the wounds." It has been my lot to see several such cases ending fatally, even in my own friends. In the hands of trained gynæcological surgeons it has become the most successful major operation known to surgery, and although removing part of the uterus in some cases with the tumour, yet these patients are able to live perfectly happy married lives, and even spinsters can get married when it was impossible before, on account of the obstruction caused by the fibroid tumour.

Finally, the researches of Lister and Pasteur have assisted gynæcology in the treatment of the fatal disease of carcinoma of the uterus. The only successful treatment at present is abdominal pan-hysterectomy. The immediate risks are great, but the remote consequences are much better than removal by the vaginal route. It only must be remembered that the peritoneum must on no account be fouled by the cancer material, or secondary growth is certain. In the last two years I have been lucky enough to do seven

cases successfully, without any return at the present time.

I must ask your forgiveness if in my keenness and interest in a subject to which I have devoted so much study and practice I have tried your kind attention severely. It is a difficult subject and not the most pleasant, yet it cannot be overlooked that it affects not only the present generation, but even more the generations of the future, and is connected directly or indirectly with every branch of medical and surgical work.

NOTES ON SOME BRISTOL MEDICAL SOCIETIES.

BY

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DURING my investigations into the history of the Bristol Royal Infirmary I have come across many references to societies and clubs founded in Bristol during the eighteenth and nineteenth centuries. Several of these were Book clubs, formed for the purpose of circulating medical and surgical books amongst the members; others were for the discussion of pathological and clinical matter, for reading papers on scientific subjects, and so forth. Nearly all were strengthened and made more interesting by a social element, in the form of an occasional dinner or supper at private houses, or at some well-known tavern, etc.

It seemed to me that these notes were worth a permanent record, not only because they throw light on medical activities in our city, but because they give some idea of

social life during an interesting period, and add something to our knowledge of many Bristol practitioners whose work should not be forgotten.

I am indebted to that storehouse of information, the *Richard Smith Memoirs*, for the greater part of the facts I have put together; also to old Bristol newspapers and articles scattered through medical and other journals.

A Bristol Medical Society

was founded about the year 1788. The meetings were held in the Committee Room of the Infirmary.

Mr. David Davies, writing to Richard Smith in 1831, says that it "originated in a friendly feeling subsisting at that time between the following members and some others, whose names at present I do not recollect: Brickenden(1), Dyer(2), Dyer(3), Fox(4), Griffiths(5), Lax(6), Maurice(7), Jardine(8), and Davies(9). It was dissolved in 1793 or 1794 by the sale of the books which had been purchased: but the Donations, of which we had several, were placed in the hands of the Treasurer until another Society should be formed. Medical papers were read and discussed, and the members occasionally partook of a supper.—D. D., 1 June, 1831."

(1) Thomas Brickenden, apprenticed to Mr. Thomas Griffiths, and a pupil of Mr. Noble. He had a large practice afterwards in London, and is mentioned by Sir Astley Cooper in his work on Hernia.

(2) Probably W. Dyer, apothecary, uncle of (3) T. W. Dyer, elected Apothecary to the Infirmary, 1759.

(4) E. Long Fox, Physician to Bristol Royal Infirmary, 1786–1816.

(5) Thomas Griffiths, elected Apothecary to the Infirmary, Dec. 2nd, 1783.

(6) Robert Lax, a greatly-esteemed practitioner in Queen's Square. Became Mayor of Wells.

(7) William Maurice, pupil of Mr. Hetling. Became Army surgeon, and received medal for services at Quatre Bras and Waterloo.

(8) Lewis John Jardine. Apprenticed to Mr. Yeatman, 1781. Elected Surgeon to St. Peter's Hospital, Feb. 14th, 1788. Twice applied for Surgeoncy at Infirmary. Died about 1824.

(9) David Davies. Had a large practice in Bristol. Married Miss Dolman of Stokes Croft in 1783. One of his bills for attendance on Mr. Catcott is in existence. The items are chiefly "electuaries" and draughts. There is a note written in Richard Smith's *Memoirs* as follows: "Mr. Nelson, with whom Mr. Davies was, recommended him to stick up to Miss Dolman, who had good property. Mr. Davies said, 'O Sir, I cannot, I have no pretensions.' 'Pretensions,' replied Mr. Nelson, 'nonsense, why you are a good handsome fellow. I will lend you £30 to go a-courting.'"

Probably this was revived, for there is in existence a list headed "Bristol Medical Society," which was found fastened in a book,[1] published in 1805, evidently belonging to some book club. It contains ten names: Messrs. Shute, Lassalle, Rolfe, Wallis, Phillips, Prowse, Rich, Hill, Williams and Allen.

There is another list, belonging to some circulating book club, with the date 1796–97, with twelve names, viz.: Beddoes, Stephen, Crawford, Nott, Renaudet, Fox, Cox, Moncrieffe, Plomer, Lovell, Carrick, and Burrow. As six of these were at different dates physicians to the Infirmary (Crawford, Fox, Moncrieffe, Plomer, Lovell and Carrick), I think it probable that this was the

INFIRMARY MEDICAL READING SOCIETY,

which was in existence as late as 1819, and consisted then of people connected with the Infirmary (but not at that date on the Hon. Staff), together with other practitioners.

Dr. Renaudet was an American Refugee who lived in Dowry Parade. He led an idle life, doing little but take short walks in sunny weather, "with a muff on his hands and a Spanish lap dog under his arm." Richard Smith, senior, called on him one morning at eleven o'clock and found the doctor still in bed. In a cupboard in the room he saw an object which

[1] In the possession of Dr. A. B. Prowse, November 30th, 1893.

puzzled him, and on inquiry was told that it was a boy airing Renaudet's wig; he did this by wearing the large peruke every day for two hours, in order that it might be properly warmed by a "gradually acquired animal heat."

The Medical Book Society.

was founded on January 1st, 1796, chiefly by the organisation of Francis Cheyne Bowles, at this time a young man of 25 years of age, full of energy, and a strong advocate of the rational teaching of anatomy by dissection. He was appointed Treasurer of the Club at its first meeting. The original members were: Thomas Baynton, Thomas Griffiths, W. Henry Goldwyer, S. S. Salmon, Thomas Shute, David Davies, Richard Smith, T. W. Dyer, James Dew, John Newman, Samuel Williams, and Francis Cheyne Bowles.

Thomas Baynton was in busy practice in the house which was then "No. 50 in the Old Market, within a few doors of the turning by the Chappel into Jacob Street." He was at this time 34 years of age, and was widely known.

W. Henry Goldwyer became famous as the founder of and first surgeon to the Hospital for Diseases of the Eye in Maudlin Street.

S. S. Salmon was born on February 8th, 1768. He applied twice for the Surgeoncy of the Infirmary.

The first copy of the rules, written on January the 1st, 1796, states: That the objects of the Society were for "promoting a friendly intercourse among its members, and purchasing medical books."

The meetings were to be held at members' houses, in rotation, on the first Friday in every month, at six o'clock "to take tea and converse on medical subjects." There was an annual subscription of half a guinea, and at the end of the year the books were to be sold by auction "to the best bidder"; and "such books as will not produce half the prime cost become the property of the member who propos'd them at that price."

Each book was to be kept a certain number of days, and the member who broke this rule was fined 6d. for each day he detained the book beyond this limit.

These rules are so like those of the present Medical Reading Society, which was established in March, 1807, that I was inclined to think the two were connected, one as the direct successor of the other; and this *may* be the case, for I can find no reference to the "Medical Book Society" after 1807. It was, however, in existence on Feb. 14th, 1807, and at this date the members were the same as at its foundation, except Mr. James Dew; *whereas not one of these* are amongst the eleven original members of the Medical Reading Society. It is, therefore, probable that the two societies were quite distinct. This is almost proved by the fact that Mr. Richard Smith mentions that Richard Lower became a member of this society in 1807, and he must have joined after February 14th, 1807, as his name is not down in the circulating list at that time. It is not likely that he would have joined a few weeks before the dissolution of the society.

The Medical Reading Society

was founded on March 28th, 1807, with similar objects and rules to the Medical Book Society. This is still in full vigour, after the lapse of a hundred and seven years. Some of those now (1914) belonging to the Society remember one or two of the original members. A full and interesting account of this, by Mr. L. M. Griffiths, will be found in the *Bristol Medico-Chirurgical Journal* for September, 1907.

The Bristol Medico-Chirurgical Society.

This was formed early in the year 1812. Its objects are stated in the following preamble: "That it being the wish of several Medical Gentlemen that a Society should be formed for the promotion of friendly intercourse amongst its

members, and for the circulation of Books—resolved: That it be called the Medical and Chirurgical Society, and consist of twelve members only. To meet every third Tuesday at 6 o'clock at each other's houses. Supper each night. Sale of Books in December."

The first meeting was held at Mr. Henry Daniel's house on April 23rd, 1812, and the rules were signed by the following:—

Richard Lowe.	Samuel Williams.
Richard Edgell.	W. H. Goldwyer.
Nathaniel Smith.	J. Newman.
James Crang.	Richard Smith.
Henry Daniel.	J. Bedingfield.
Geo. G. Bompas.	James Daly.
Robert Lax (Treasurer).	Richard Charles Hanson.
Robert Dyer.	William Salmon.

Presumably a ballot was taken, and in the first printed list to be found the above names are down with the exception of Crang, Daly, Hanson, and Salmon. In 1819 the last three appear as members, and Bompas, Dyer and Newman are omitted.

It is uncertain how long this first Medico-Chirurgical Society existed, but there is a letter from William Salmon to Richard Smith, dated "14th Feb., 1825, 23 King's Square," as follows:—

DEAR SIR,

The Medical and Chirurgical Society meet at my house to-morrow evening. If you will favour me with your company at supper, I shall be happy in receiving you.

I am,
My dear Sir,
Your obligd. servant,
WILLIAM SALMON.

Another letter, from W. Salmon to R. Smith, dated "Sept. 2nd, 1825," is an invitation to the "Montague" to

sup with the members of the *Medical Social Society*. This probably refers to another society, called

THE MEDICAL AND CHIRURGICAL ASSOCIATION.

which was formed at a quarterly meeting of the Faculty of the Infirmary, held at the Montague Hotel, Kingsdown, on Dec. 8th, 1818. Dr. J. Cowles Prichard and Mr. Richard Smith were deputed "to consider some plan which might promote a friendly intercourse between respectable members of the profession in general," and to report "at the next meeting of the Faculty of the House to be holden on Tuesday, ye 9th of March, 1819." On January 15th, 1819, Messrs. R. Smith, Hetling and Lowe, and Dr. William Gilby, met at Dr. Prichard's house in College Green to consider what means to adopt, and decided to call a meeting of the Faculty at Mr. Richard Smith's on January 25th, and to invite some other medical men to be present.

At this meeting on the 25th Dr. Carrick (the Senior Physician to the Infirmary) was called to the chair, and it was resolved that "a society be formed under the title of the Medical and Chirurgical Association." The Faculty of the Infirmary were constituted a Committee, with power to add to their number, and the objects of the new society were agreed upon as follows: "To promote a friendly intercourse between the Medical and Surgical Professions in Bristol and its vicinity, and to advance the general interests and respectability of the Profession"—and "in order to promote the interests of the Profession, and in order to obtain a fair and adequate remuneration for attendance it shall be an object of this Association to enter into a general understanding with regard to the sum to be charged for visiting at certain distances."

The Committee met at Dr. Prichard's on March 27th, 1819. They decided "that the most likely method to accomplish

the objects desired will be to establish a meeting to be held at the 'Montague' twice a year, in order to dine together: and to ensure a full attendance at each dinner each member is required to deposit in the hands of the Secretary one guinea."

The next meeting of the Committee was at Reeves's Hotel on Saturday, April 3rd, 1819, when Richard Smith was unanimously elected Treasurer and Secretary, and some necessary rules as to election, etc., were passed.

It will be seen that the scope of this Medical and Chirurgical *Association* was different from that of the *Society* of the same name. It was meant to appeal to the profession at large, and had nothing to do with books. It was, in fact, an attempt to organise a social and ethical society for local practitioners.

It will be noticed that the question of fees was to be considered, and it may interest my readers to know that the following resolutions were agreed to:—

1. That the Physicians and Surgeons of the Infirmary and the Senior Members of the Profession generally should consider themselves on a par in regard to charges.
2. The Faculty of the House, together with the Senior Members of the Profession ought to be allowed the cost of a Post Chaise when they go a distance beyond two miles (whether they use their own carriage or not).[1]
3. That a distinction ought to be made between a single visit or two and a regular attendance.
4. All operations are to be paid for independently of the journeys.

[1] The suggested charges for distances were: Clifton, 10s. 6d.; Bedminster, £1 1s.; Redland, £1 1s.; Brislington, Westbury and Ashton Church (each considered about three miles), £1 1s. to £2; Leigh, Henbury and Shirehampton, £2 2s.; Keynsham, Pill, Wraxall, Mangotsfield and Siston(?), £3 3s.; Pensford, £4 4s.; Wrington, £5 5s.

5. Practitioners who furnish and charge for medicines will probably be satisfied with smaller fees for attendance.

6. Less than a guinea ought not to be charged for a visit in the night.

There was an understanding amongst the members that these charges should be adhered to as much as possible, but no one was bound to follow them strictly.

The first dinner was held at the "Montague" on Thursday, May 6th, 1819, at five o'clock. The price was 7s. each, exclusive of wine. The second was held on October the 7th.

The next year (1820) Richard Smith resigned the secretaryship, and Richard Edgell was appointed in his place.

Richard Chafin Edgell, or Edgehill, was born at Frome in 1776. He was indentured to Mr. Joseph Metford as an outdoor apprentice for 200 guineas. He became Surgeon to the 2nd Somerset Militia in 1799. He applied three times unsuccessfully for the Surgeoncy of the Infirmary. He had, I believe, no qualification, but enjoyed an extensive practice in medical and midwifery cases, making £1,500 a year. He was an eminent Freemason.

Amongst many letters in answer to the notices of these dinners, I find the following rather curious one :—

DEAR SIR,

It will not be in my power to attend the next meeting of the Medical Association (*sic*).

As there appears to me no particular object in this Society but that of occasionally dining together, for which I have but little time and not much inclination, I will thank you not to insert my name in any list of future subscriptions.

I am,
Yours truly,
JOHN BISHOP ESTLIN.

April 30th. 1820.

John Bishop Estlin, M.R.C.S., F.L.S., son of the Rev. John Prior Estlin, LL.D., minister at Lewin's Mead. He was well known and greatly esteemed as the founder of the Eye Dispensary in Frogmore Street, and as a lecturer on Diseases of the Eye and Optics. He also lectured at the Bristol Institution on the "Structure of the Human Body," etc. He applied four times, unsuccessfully, for the post of Surgeon to the Infirmary. His sister married Dr. J. C. Prichard.

This Society lasted some years, but settled down (as intimated in Mr. Estlin's letter) into a social meeting at dinner twice a year, and it does not appear to have done much else.

These purely local societies must not be confounded with the local branch of the Provincial Medical and Chirurgical Association, about which a word or two must be said.

The Provincial Medical and Chirurgical Association,

which was usually, after its beginning, called the Provincial Medical and Surgical Association, was at first confined to the provinces—London was afterwards included—and it ultimately became the British Medical Association.

It was initiated at the Worcester Infirmary on July 19th, 1832, chiefly owing to the exertions of Dr. Charles Hastings, who gave an inaugural address. He and Mr. Sheppard were appointed Secretaries. Dr. Johnstone, of Birmingham, was elected President, and Dr. Carrick, of the Bristol Infirmary, was elected President for the year 1833–4.

A Council was formed, which included four men on the Infirmary staff, viz. Drs. Prichard and Carrick, and Messrs. R. Smith and W. Hetling.

The first anniversary meeting was held at the Infirmary, Bristol, on July 19th, 1833, in the Committee Room. Dr. Carrick, the Senior Physician, was in the chair, and gave an excellent address.

About two hundred members assembled at 11 o'clock. The wards and new out-patient room of the Infirmary were inspected, Dr. Carrick gave his address, and Dr. Hastings read his annual report. Dr. Barlow, of Bath, gave another eloquent address, and various resolutions were passed, and much business transacted. The meeting broke up at half-past 4 o'clock, and the company re-assembled at 6.30 at Ivatt's Hotel, where they sat down to a dinner which did credit to the caterer, the turtle, dessert and wines being very favourably mentioned in the papers. Messrs. Richard Smith and William Hetling acted as Vice-Presidents.

Formation of a Local Branch.

A proposal to form a local branch of the Association was made at a meeting of doctors in Bristol in June, 1839.

A year after, on June 18th, 1840, a well attended meeting was held at the Medical Library in Orchard Street. Dr. J. C. Prichard was in the chair, and delivered an address, in which he claimed that Bristol was peculiarly fitted " to become the seat of a Medical University," both from its position, the existence of the Infirmary, Hospital and Medical School, and because " the intellectual resources for founding an University are within our reach " (*Felix Farley's Journal*, June 20th, 1840).

When we remember that at this time such men as John Addington Symonds, W. B. Carpenter, William Herapath, and J. C. Prichard were lecturing in Bristol, and were organising and leading medical education in the West of England, we can heartily agree with him.

Dr. Wilson moved at this meeting " that the proposal in June, 1839, for forming the Branch Association be adopted. Mr. Hetling, the Secretary, read the proposed rules, and our friend Richard Smith was elected the first President of the Bristol Branch.

After further business the meeting adjourned until 3 o'clock, when a discussion on puerperal fever was opened by Dr. Symonds, and at 5 o'clock there was a "sumptuous dinner" at the Royal Western Hotel, with Dr. J. C. Prichard in the chair, and Richard Smith as Vice-President. According to the newspaper report "the hours winged their flight during a delightful flow of conversation."

The Bath Branch was founded before this, on Nov. 18th, 1836. The two branches were amalgamated in 1842.[1]

From its foundation until 1863 many Bristol men contributed important papers, especially Symonds, J. C. Prichard, Budd, Wallis, Augustin Prichard, and Davey. Budd made a strong advocacy of photography in medicine at the Torquay meeting in 1860.

The Association met again in Bristol on August 5th, 6th, and 7th, 1863.

In the preliminary notices of the meeting the three hotels mentioned as "among the best" are the "Queen's," the "Bath," and the "White Lion." Dr. Symonds gave the Presidential Address at the Victoria Rooms, and in the evening there was a conversazione, with electrical experiments by Mr. Phillips, of Weston-super-Mare, and a pathological museum was on view, arranged principally by Dr. Samuel Martyn. Supper was served at 11 o'clock. A contributor to the *Bristol Times* said, "I never saw people eat with so great a contempt for the nightmare as did the professional part of the company. . . . Everything you could conceive unwholesome to retire to bed upon, from lobster salad to pork pie, was swept down before the repeated *charges of these dyspepsia defying lancers.* I jogged the elbow of my medical attendant just as he went in for a third helping of raised pie, half a plateful of which would have made me dream that I had the Observatory on, or a plesio-

[1] *Brit. M. J.*, 1882, I. 956.

saurus in, my stomach. 'Pray remember the poor inside,' I said. 'See if you can reach that decanter of sherry for me,' he merely replied, with his mouth half full."[1]

But this meeting of 1863 should be remembered by Bristolians chiefly because of the address in medicine, which was delivered by Dr. William Budd, and was entitled, "Variola Ovina and the laws of contagious Epidemics, illustrated by an experimental type."

In this paper he not only clearly expressed his belief in the recent researches of Pasteur, which had not then gained much ground in England, but he carried the theory of germs as factors in disease to a length never before attempted in this country; and was within a short distance of anticipating Lord Lister's brilliant work.

The address was about an epidemic resembling small-pox in sheep, which ravaged the Wiltshire flocks in the autumn of 1862. It was a contagious eruptive fever, spread, as Budd declared, by flies, starlings, human contact, or in the atmosphere. He reasoned that this poison which killed the animal was produced in the sheep's body, not spontaneously, but from entrance of germs of extreme minuteness and with an "incalculable faculty of growth." He pushed the analogy of this epidemic to the consideration of typhoid and other contagious diseases, and was emphatic in condemning the theory of "spontaneous generation."

[NOTE.—The Provincial Medical and Surgical Association printed *Transactions* from 1833 to 1853. *The Provincial Medical and Surgical Journal* ran from 1840 to 1852. There were thus *two* journals connected with the Association in existence at the same time during a period of twelve years. In 1853 the name of the last was altered to the *Association Medical Journal*, and in 1857 this was again changed to *British Medical Journal*.]

[1] *Bristol M.-Chir. J.*, 1894, xii. 172.

The Association met for the third time in Bristol in 1894. This is so recent that no special notice is required of it here, except to remark that the address in Surgery by Greig Smith, given in Victoria Chapel, will remain in the memories of many who heard it as a masterpiece of eloquence.

The Bristol Medical Library.

The "Bristol Library Society" was founded on Dec. 15th, 1772. Its chief interest to medical men is that John Ford, Samuel Farr, and Abraham Ludlow, all at that time on the Hon. Medical Staff of the Infirmary, were amongst the most active of the promoters of the scheme.

On Saturday, June 18th, 1831, Dr. Edward Kentish, Mr. T. L. Surrage, and Mr. William Mortimer called upon Richard Smith to discuss the question of forming a medical library. Of these, Dr. Kentish, who founded the "Kentish Baths" near the Cathedral, was the most active organiser, and may be said to have been the founder. He was the first President, and was succeeded, on his death on Dec. 8th, 1832, by Dr. Carrick, who was then Senior Physician to the Infirmary.

Dr. Carrick died on June 14th, 1837, and Dr. J. Cowles Prichard, F.R.S., then Senior Physician to the Infirmary, was elected President on June 26th, at the Annual Meeting. At this time Dr. P. T. Dick was Secretary, Mr. Surrage Treasurer, and Mr. Thomas Green Librarian.

The Library had its head-quarters in Orchard Street in a building formerly used by the French Protestants who came to Bristol after the revocation of the Edict of Nantes. The Society paid the Corporation £2 a year rental.

In 1856 the books were transferred to the Bristol Library, which was in "the west wing of the Bishop's College, on ground now occupied by the Art Gallery."[1]

[1] See Mr. L. M. Griffiths' account of the Medical Library, *Bristol M.-Chir. J.*, 1911, xxix. 338.

After the establishment of the *Bristol Medico-Chirurgical Journal* in 1882, a number of books sent for review and journals sent in exchange, etc., began to accumulate: the urgent need of a Medical Library in some central and convenient situation was felt, and in 1890 these books, together with the remnant of the old Medical Library, were transferred to the newly-formed Literary and Philosophic Club in Berkeley Square.

On July 1st, 1893, the Library was removed to a fine room specially constructed for the purpose in the Medical School Buildings, now forming part of Bristol University.

As the origin of these buildings, at first known as the "New Medical Wing of University College," is becoming "ancient history," it may be as well here to add a few notes on the subject.

The "old" medical wing of University College was a red brick building, described by Dr. Lyon Playfair as "barn-like," part of which still survives. Work was carried on here from 1879 to 1892, with the help of large rooms belonging to the University College. In one of the lecture rooms in this old building a largely-attended meeting of medical students and young practitioners was held on Oct. 28th, 1887. The object was to consider some means of increasing the accommodation at the School. It was decided to represent to the Faculty of Medicine the urgent need for larger and better equipped buildings. A Committee was appointed, of which Mr. Munro Smith was Chairman, Dr. Michell Clarke Treasurer, and Messrs. Mole and Gratte Secretaries.

On Nov. 4th, 1887, an interview was granted to this Committee by the Faculty of Medicine of the University College, and a sub-committee of the Faculty were appointed to consider the question.

On Nov. 15th, 1887 this sub-committee, together with members of the committee appointed by the students on

Oct. 28th, met at Dr. Markham Skerritt's to consider chiefly the best means of collecting money for the proposed new buildings. It was decided to issue circulars, first to the medical profession in Bristol and neighbourhood, and then to the general public, asking for contributions.

The following day, Nov. 16th, the committee interviewed the Council of University College on the subject.

On Feb. 16th, 1888, certain representatives of the conjoint committee of the Faculty and students, viz. Dr. Skerritt, Prof. Lloyd Morgan, Dr. Michell Clarke, and Mr. Munro Smith, met Mr. Albert Fry, Mr. Schacht, and the Secretary of the University College, to discuss "the legal business" connected with the proposed new wing. [1]

On March 6th there was a meeting to discuss plans of the building.

In the meanwhile other medical men in Clifton and Bristol had been interested in the subject, and many informal meetings and discussions took place at private houses. Amongst others, Dr. Ed. Long Fox, then Consulting Physician to the Royal Infirmary, took up the matter in a practical manner, and gave a dinner on Saturday, June 2nd, 1888, at the Queen's Hotel, principally to medical men interested in the School.

Dr. Fox, who always made an excellent chairman, gave us a first-rate dinner, and then made a speech in which he laid great stress on the urgent need for better accommodation in the Medical Department of University College. He spoke especially of the importance of having a good museum, and a large room which could be used both as a library and as a place of meeting for the Medico-Chirurgical Society, and the local branch of the Medical Association. Everyone was very enthusiastic, and when a list was sent round no less

[1] These notes are taken chiefly from my diary, and from a sort of minute book which I kept at the time.—G. M. S.

than £1,200 was promised by those present in contribution to the scheme.

On Dec. 3rd, 1888, a meeting of the Building Committee was held at the Medical School, and Mr. Hansom, the architect, submitted plans of a four-storied building, with the museum on the second floor, and a library on the ground floor.

On Dec. 17th, 1888, Mr. Greig Smith was added to the Building Committee, and objected in his impetuous and energetic way to the plans, which had hitherto been thought good ones; and on Jan. 4th, 1889, a three-story plan, with the Library above and the Museum below, was adopted by the Faculty.

In the meanwhile the medical men of the neighbourhood had been circularised, and by June 7th, 1889, the total subscriptions from the profession alone amounted to £1,709 14s. This money was contributed to the Building Fund, but the real actuating motive was undoubtedly the wish to have a good medical library for the use of the Profession in the neighbourhood, a place for meetings, and a museum; and of these the foremost object was the hope of a permanent room for the Library.

This formed the nucleus of a sum of money which, when added to by grants from the University College, was expended on the new buildings. The individual lecturers had much to say as to the arrangement of their respective departments, but by far the greatest amount of thought was bestowed on the Library.

Amongst other things, stone shields were were placed on the walls, with monograms of well-known Bristol men upon them; and the six chosen were Henry Riley, Henry Clark, William Herapath, John Addington Symonds, Joseph Griffiths Swayne, and William Budd.

Above the entrance to the building is the motto—

"ὁ βίος βραχύς ἡ δὲ τέχνη μαχρή."

The new buildings were formally opened on Nov. 16th, 1892.

Bristol Royal Infirmary Medical Society.

This was founded towards the end of 1850 by students and junior medical men in connection with the Infirmary. Mr. Henry A. Hore, then House Surgeon, was the first President, and Messrs. E. H. Swete and W. Garrard were Hon. Secretaries; Mr. Nathaniel Crisp (elected Assistant House Surgeon in May, 1851), was Vice-President; and Mr. Crosby Leonard, then recently qualified, was the Hon. Treasurer.

From the Annual Report, a modest little pamphlet, with a blue paper cover, we find that at the end of the first session there were thirty-four ordinary members; the Hon. Staff were patrons; and the balance at the end of the year was £3 6s. 9d.

On January 7th, 1851, Mr. Harrison, the Senior Surgeon, "asked permission for the use of the Board Room once a fortnight on behalf of a Medical Society recently formed by the students of the institution for promoting a spirit of enquiry into and discussion of, medical topics."

This request was granted by the Committee, on condition that "one of the Physicians or Surgeons, together with the House Surgeon, be present during the whole of the meeting."

Fourteen meetings were held during the session, and were well attended. Interesting subjects were discussed, and two annual prizes were given, one for the best essay on a given topic, and one called "The Discussion Prize," presumably for the best speaker or debater.

Like other societies, it did well so long as it had an energetic secretary. After a few years it languished and ceased, but was revived again in 1869. On March 23rd of

that year Mr. Board, the House Surgeon, attended a committee meeting, and asked for a renewal of the privileges granted in 1851. This was agreed to by the Committee, and the Society continued in a moderately thriving condition for some years.

THE CLINICAL MANIFESTATIONS AND TREATMENT OF COLIURIA IN CHILDREN.

BY

R. G. GORDON, M.D., B.Sc., M.R.C.P. Ed.

IN adults coliuria is an obvious and common complaint, which is chiefly interesting by reason of the difficulty in establishing a lasting cure, but I do not suppose that there is any affection of childhood in which one is so frequently led astray.

In adults one may say that one's attention is almost always drawn to the urinary tract, and that in consequence one obtains a sample of the urine and at once the diagnosis is plain; but in children there may be, and quite often are, no urinary symptoms, and although routine examination of the urine ought theoretically to be carried out, everyone knows how extremely difficult it is to obtain an uncontaminated sample from the infant and young child, especially in the female sex. For these reasons the diagnosis is often very difficult, and the condition is missed over and over again. When one comes to examine the clinical manifestations, one is at once struck by the fact that they present a confused heterogenous group of symptoms, some of which are exhibited by one case and some by another, and I propose to try to arrange these symptoms into groups, so that one

may classify one's cases, giving illustrative cases of the various types.

Firstly, cases may be divided into acute and chronic, of which the acute are the most numerous, present the most interesting pictures, and are most amenable to treatment.

From the observation of a series of cases in a children's hospital, and from a study of the literature, five groups of acute cases suggest themselves, viz. :—

1. Those presenting general symptoms without reference to any special symptom.
2. Those with nervous symptoms predominating.
3. Those with pulmonary symptoms predominating.
4. Those with gastro-intestinal symptoms predominating.
5. Those with urinary symptoms predominating.

For example—

A girl aged five years and four months was sent to hospital for diagnosis. Six weeks before admission she had slight pain and inflammation of the throat, adenoids having recently been removed. The temperature went up to 105°, and had continued swinging ever since. Three days after the onset there was severe pain in the back lasting twelve hours. The bowels had been confined, the appetite poor, and the child irritable and difficult to manage.

On admission the child looked pale and ill, but physical examination yielded nothing, and there were no urinary symptoms, but on examining the urine it was found to be acid, to contain epithelial and pus cells, and on cultivation yielded a pure growth of *Bacillus Coli*.

This case I should place in the first group, and such cases are marked by a sudden onset of high fever, often accompanied by rigors, which, by the way, are very suggestive of coliuria when they occur in children, by convulsions or sudden collapse. If untreated, the temperature may swing for weeks, and the charts often simulate typhoid or malaria. There is often marked restlessness and irritability and sometimes pronounced muscular tenderness, but no symptom pointing to any special system.

The second group specially tends to simulate meningitis, and these cases may be delirious, convulsed or drowsy, and even comatose. They may show neck rigidity, strabismus, and even Kernig's sign, while extreme irritability and frequent screaming fits seem to complete the picture of meningitis. There are no urinary symptoms, but the urine is found to contain pus and *Bacillus Coli*, and on treatment they recover.

The following is a good example :—

A girl aged seven and a half months, rather constipated but otherwise healthy, was suddenly taken ill one evening with a temperature of 104°. Next morning she was unconscious, with the body extended and rigid. This latter condition lasted an hour, and she was semi-conscious till afternoon, when she had right-sided convulsions with deviation of the eyes to the right, lasting for three hours. She was given bromide and chloral per rectum, and then chloroform was administered for one hour, after which she slept for six hours. On waking the temperature was 100°, and she was paralysed in the right arm and leg, but not in the face. After a few days the paralysis passed off. Four days later the temperature rose to 104° without apparent cause, and continued swinging for three weeks, with no rigors or fits, but with periods of unconsciousness at intervals, in one of which the pulse rate increased to over 200. All this time there were no urinary symptoms, but one day the nurse noticed peculiar staining on the napkins, and the urine was collected and examined. This was found to contain pus and *Bacillus Coli*, so she was treated accordingly, and made an uninterrupted recovery. Five years after she is a healthy, intelligent child, and has had no further cerebral trouble whatever.

The third group leads one to expect that some pulmonary trouble, pneumonia or acute bronchitis, is about to develop. The onset is attended with tachypnœa and sometimes dyspnœa, together with high temperature and malaise. A few râles may be heard at the bases, but the signs never develop though the symptoms persist, and it is not until the urine is examined that the true cause is elicited.

Thus :—

A girl aged eleven months was admitted to hospital with a history of cough, dyspnœa, and twitching of the eyes of two

days' duration, the onset being accompanied by vomiting. On examination the child presented a typical pneumonic appearance, with inverted breathing, but beyond a few râles there were no signs in the lungs and no consolidation was ever present. The urine, however, showed pus and bacilli, and treatment directed to this had a satisfactory result.

In the fourth group the onset is attended by severe colicky pains in the abdomen, vomiting, obstinate constipation, or in some cases diarrhœa. The appetite is lost, and in a few cases jaundice is present. There are, however, no localising signs till the urine is examined.

Thus :—

A girl aged eleven months was admitted to hospital with diarrhœa and vomiting, accompanied by screaming fits, attributed to colic. She was irritable and feverish, and her condition had resisted the usual methods of treatment, but on the urine being examined a condition of coliuria was discovered, and recovery rapidly ensued on the treatment of this condition.

Fifthly, we have the cases which do present urinary symptoms, which of course form the largest individual group, but from such statistics as are available they would only seem to amount to 50 per cent. of the whole. In such cases there may be a palpable tender kidney which may vary in size as in hydronephrosis, and they all present symptoms of cystitis—frequency and screaming during the passage of urine. Such symptoms may be intermittent, but continue unless treatment is adopted. It is hardly necessary to cite such a case, as they are quite common and the diagnosis is fairly obvious.

So much for acute cases, and in passing it may be remarked that all these symptoms must be attributed to the circulation of toxins produced by the bacilli, and evidence of this is afforded by the results of treatment. It is unnecessary to dwell on the chronic cases. A case which has started acutely may become chronic if untreated, and although it

may apparently recover spontaneously, it breaks out afresh from time to time, and this state of affairs may go on for years.

In older children one may get a condition more closely resembling the disease as manifested in adults. This is attended by a gradual onset passing on to anæmia, emaciation, and often extreme debility. Such cases suffer from periodical attacks of nausea and vomiting, with slight pyrexia, and may have enlargement of the liver and spleen. There are usually some urinary symptoms, and the urine is, of course, diagnostic. The prognosis of acute cases is eminently good, provided they are recognised early and properly treated. Relief of symptoms may be expected in the course of a very few days, and a cure established within a short time.

In cases which are or have become chronic, however, prognosis is less favourable, and they often require prolonged treatment before they are cured, while some cases succumb to the toxæmia in spite of all. In considering treatment, it must be remembered that relief of symptoms does not constitute a cure; the latter can only be assumed when the urine is clear of pus and bacilli.

In 1902 John Thomson published twenty-five cases which were treated by alkalies (potassium citrate and sodium bicarbonate), and in all cases the symptoms were relieved. He supposed that the alkalinity of the urine induced by these drugs was inimical to the growth of the Bacillus Coli, and that a cure was thus accomplished. Since then, however, it has been found that this "alkaline treatment" relieves the symptoms, but by no means always frees the urine from pus and bacilli, and Jordan has conclusively shown that the *Bacillus Coli* can grow as well in an alkaline as in an acid medium, hence it is to be presumed that the "alkaline treatment" neutralises the toxins produced, which

in some cases is sufficient to enable the patient to cope with the infection and throw off the disease. Of late years Thompson Walker has shown that coliuria may be cured, at any rate in acute cases, by the administration of hexa-methylene-tetramine, combined with agents which will render the urine acid, and that this only fails if the urine is insufficiently acid, and that then the best agent for obtaining acidity of the urine is acid sodium phosphate, which may be pushed to large doses without ill-effects.

Thus, given a case with severe symptoms, the urine should be rendered alkaline until such symptoms have subsided, and then hexa-methylene-tetramine and acid sodium phosphate given until the urine is free from pus and organisms, remembering that the latter are chemically incompatible, and therefore must not be dispensed in the same bottle.

While such treatment will cure most cases, some chronic cases will not yield to it, and in these vaccines provide a valuable adjuvant—drug treatment should not be discontinued—but vaccines must be autogenous, as only 30 per cent. of cases are due to the true *Bacillus Coli*, most of the other members of the group being the causal organism in certain cases. Further, large doses are required; one may commence with a dose of ten millions, but it is rare that good results are obtained under fifty millions, and it is sometimes necessary to proceed to 200 or 400 millions before a cure can be effected.

SOME IMPRESSIONS OF THE 1914 BRITISH PHARMACOPŒIA.

BY

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THE present contribution is a somewhat modified account of a paper brought before the Bristol Medico-Chirurgical Society by the writer on November 11th.

No attempt has been made to treat the matter in minute detail, and only certain outstanding alterations have been dealt with and criticised, and special reference has been made to those subjects which concern medical practitioners.

One of the most striking features of the new work is the introduction of the metric system of measuring and weighing drugs for the various preparations without giving at the same time directions involving the use of the Imperial System. The doses, however, are given in both systems, which is fortunate for many people. The "standard litre" is taken as the volume of one kilogram of water measured at 4° C.; the volume of 1 gm. of water also measured at 4° C. is termed a "millilitre" or "mil," and this is sub-divided into the "decimil" and "centimil."

During recent years there have been many discussions concerning the relative efficacy of pure chemical compounds and indefinite preparations in medical practice. There can be little doubt that the medicinal values of drugs were originally determined by observing the effects of crude natural products when administered internally; as a natural sequence to such discoveries it became obvious that in many cases a better result could be obtained by giving the soluble

constituents of a drug without the insoluble inert matter, and in this way infusions, decoctions, extracts, and later tinctures, came into general use. At a comparatively recent period such a system was purely empirical, as neither the active principles of drugs nor their physiological action had been investigated.

With the rise of organic chemistry and pharmacology during the last century numerous organic compounds were isolated in a state of purity from crude drugs, and in many cases their action has been investigated by experimental pharmacologists. Such researches have laid the foundations of a rational system of pharmacology, and the further introduction of very numerous synthetic drugs has greatly strengthened this system. It must be freely admitted that such a system is at present very far from perfect, and very greatly in need of improvement, but it is surely the only one that can eventually put clinical pharmacology on an absolutely firm basis.

One fully recognises that with our present state of knowledge we are compelled to retain a considerable number of very valuable preparations, such as Tinct. Nucis Vom., Tinct. Opii, etc., etc.; in fact, there is no reason why such well-established galenicals should ever fall into disuse, but in the writer's opinion too many new preparations of a similar type have been introduced. For example, it seems superfluous to include a vinegar, oxymel, syrup and tincture prepared from Urginea Indica, in addition to the already existing corresponding preparations made from Urginea Scilla.

The introduction of preparations of this type into such an important work as the *British Pharmacopœia* is not calculated to advance the science of pharmacology. At the same time, it is inspiring to see that the vinegar, plaster, ointment and tincture of Cantharides have been replaced by

corresponding preparations made from the active principle Cantharidin.

Several synthetic preparations are included for the first time, and as mentioned elsewhere their names have been modified. Thus :—

New name.	*Name of Patent Product of same composition.*
Barbitonum.	Veronal.
Benzamine Lactas.	Eucaine Lactate.
Chloral Formamidum.	Chloralamide.
Diamorphine Hydrochloride.	Heroin Hydrochloride.
Hexamina.	Urotropin.
Methyl Sulphonal.	Trional.
Phenolphthalein.	Numerous names.

With regard to the abbreviated nomenclature adopted for some of the latter class of drugs criticism is necessary. In the case of such a compound as Benzoyl-vinyl-diacetonalkamine lactate, the full name would be rather cumbersome, and the more convenient " Benzamine Lactate " appears to be justified. But it is extremely doubtful whether the same justification exists in the case of Barbitonum, Hexamine, and Diamorphine Hydrochloride, all three of which might have well retained their constitutional names, which are respectively Diethyl-malonyl-urea, Hexamethylene-tetramine and Diacetyl-morphine-hydrochloride. This scientific method is actually adopted in the case of Trional, which being a methyl substitution product of Sulphonal is called Methyl-sulphonal.

Other important synthetic drugs have been included, and it is to be regretted that the number is not greater.

A hypodermic injection containing 0.75 per cent. of Strychnine Hydrochloride has been included for the first time.

Quite a large number of preparations have been omitted,

and several of these omissions strike one as being unsatisfactory, notably Ferri Arsenas, Ferri Phosphas, Sodii Sulphocarbolas, Zinci Sulphocarbolas, and Tinct. Jaborandi; but of these Ferri Phosph. has been replaced by a saccharated preparation, and the scarcity of jaborandi leaves may account for the deletion of the tincture.

One uncalled-for class of preparations, the Concentrated Liquors, has been deservedly removed, and this withdrawal takes away a conspicuous blot from a scientific work; if a clinician orders infusions or decoctions they should be freshly made, or there is no point in using them. The Concentrated Liquors presumably took the place of concentrated infusions and decoctions, which, though convenient for the pharmacist, do not possess the same properties as recent preparations.

With regard to those preparations which have had their concentrations altered, both favourable and unfavourable criticisms must be made. Certain of these alterations have been made in order to bring about an International Conformity, whereas others have been made for less obvious reasons. Such changes render it urgently necessary for physicians to re-learn the new strengths and doses, and this is a most unsatisfactory state of things. The clinician has so many responsibilities associated with his work, that it becomes almost criminal to burden him by compelling him to unlearn facts just to satisfy the whims of a few people.

Thus an important preparation, Tr. Strophanthi, is four times the strength of the old preparation, and the dose has been changed from 5-15 mins. to 2-5 mins. Tr. Opii now contains 1 per cent. morphia instead of 0.75 per cent., and Tr. Nucis Vom. is half the strength of the old preparation! One mercurial ointment, Ung. Hydrarg. Am., has been reduced from 10 per cent. to 5 per cent.; another, Ung. Hydrarg. Subchlor, has been increased from 10 per cent. to 20 per cent. The former change has been brought about in

deference to certain eminent dermatologists, and needs no comment. The increased strength of Calomel Ointment is doubtless due to the fact that it is largely used by a certain section of the community as a prophylactic against the unhappy protozoon Treponema Pallidum, which has to comply with the law of mass action.

It is pleasing to notice that the hypodermic injections of Cocaine and Morphine have both been reduced to one-half their former strength. This is most satisfactory, as they were formerly too concentrated to be accurately measured by the methods adopted clinically, and now there should be far less chance of error arising.

The introduction of the Metric System is responsible for at least two slight changes in strength : Syr. Chloral Hydrat. formerly contained 10 grs. in each fluid drachm, and Liq. Hydrarg. Perchlor. $\frac{1}{15}$ gr. in one fluid drachm, or approximately 0.115 grs. in 110 mins. The former now contains 200 gm. in 1,000 millilitres or 10.9 grs. in a fluid drachm, and the latter now contains 1 gm. in 1,000 millilitres or $\frac{1}{10}$ gr. in 110 minims.

The method adopted for the representation of formulæ of organic compounds calls for serious criticism in many instances. It must be realised that the *Pharmacopœia* is used as a text-book by many students, and the crude method adopted for organic formulæ does not conduce to an intelligent comprehension of chemistry or pharmacology. To take a few examples, Phenol or Carbolic Acid is represented as C_6H_6O. As a purely empirical formula this may be justified, but it conveys no idea whatever either of the chemical constitution or the probable physiological action. If the formula were written C_6H_5OH it would reveal the fact that phenol is the mono-hydroxyl substitution product of benzene, and one would expect it to give the chemical reactions of both the phenyl and hydroxyl group. One

would also surmise that the hydroxyl group could anchor the phenyl group to living protoplasm and thus enable it to bring about a physiological action.

The formula C_8H_9NO given for Acetanilide is another very striking example of the ludicrous method adopted in most cases. On reference to the latest edition of Richters' *Dictionary of Carbon Compounds* it will be found that no less than sixty-two compounds lay claim to the formula C_8H_9NO, whereas only one compound, Acetanilide, is represented by the constitutional formula $C_6H_5NH.COCH_3$.

It is curious to notice that a logical method is adopted in the case of Picric Acid, which is represented as $C_6H_2(NO_3)_3OH$!

There is one direction in which improvement was desirable, and still is so. It would be an enormous benefit to medical men if the concentrations of tinctures, spirits, liquors, syrups, and so forth, could be so adjusted that they possessed the same dose, as the variety of doses now obtaining is puzzling even to a man with a good memory, and hopeless to many; obviously certain exceptions would have to be made, but on the whole there is no serious objection to a greater uniformity of dose than now exists.

The appendix contains much valuable information, especially concerning analytical chemistry, and is in advance of previous appendices.

Progress of the Medical Sciences.

MEDICINE.

Diabetes mellitus. The well-known fact that in severe cases of diabetes the urinary sugar is only reducible to a certain point by restricting the carbohydrate intake, has been shown by Wolf and Guttmann [1] to bear an interesting relationship to the sugar

content of the blood. In uncomplicated and mild cases the blood-sugar falls to normal on appropriate diet, but as the cases increase in severity the point to which the blood-sugar can be reduced mounts higher and higher, and the minimum content for each individual patient is uninfluenced by further decrease of the sugar intake. When the urinary sugar had been reduced to zero by means of "vegetable days," in which both protein and carbohydrate were taken in very small quantities, the hyperglycæmia remained at its accustomed minimal figure, and slight increases on this amount were observed on "oatmeal" days. The blood-sugar also rose in cases of coma. Complications such as phthisis, arteriosclerosis and cirrhosis of the liver did not influence the behaviour of sugar content of the blood, but in chronic granular kidney there was increased hyperglycæmia even when the urine was permanently free from sugar, and in other cases of nephritis variations on the generally-found blood content were observed. That valuable information may be obtained by estimations of the sugar content of the blood is thus clear, but unfortunately the methods for doing so are difficult and not always exact.

Klercker,[2] also making estimations of the sugar content of the blood, found that the exhibition of the opium alkaloids had no influence on experimental hyperglycæmia induced by injections of adrenin, or by diabetic puncture. On the other hand, when alkaloids were injected in amounts which failed to influence the normal sugar content, feeding with such amounts of carbohydrate as would ordinarily exceed the animal's level of toleration failed to produce hyperglycæmia.

It has been suggested[3] that this effect on "alimentary glycosuria" may be due to a retarding influence on the rate at which the stomach empties itself, which has been shown by Magnus to be one of the results of the administration of morphia. The carbohydrates may thereby be prevented from reaching the small intestine in large quantities at a time, and thus absorption being likewise diminished, no hyperglycæmia results.

Galambos and Tansz[4] attribute hyperglycæmia to a diminution in the internal secretion of the pancreas or to some change in its activity, which interferes with the normal katabolism of proteins. Analogous to the glycosuria is a hyperaminosuria, or increased secretion of amino-compounds in the urine, which they have shown to occur in pancreatic insufficiency. A similar condition is also found in some liver diseases and in certain infections in which glycosuria may also be observed.

Nervous glycosuria. It has long been known to clinicians that emotional disturbances, especially fear and anger, can produce or increase glycosuria; recently experimental evidence has been produced showing that glycosuria occurs in cats when they are confined in cages and frightened by dogs.[5] The

reaction depends on the actual fear or rage experienced by the cats ; an interesting fact brought out by these experiments was that no glycosuria occurred if the suprarenals had previously been removed, which corroborates the view that painful emotions are accompanied by an increased discharge of the internal secretion of these glands into the blood.

Renal glycosuria has been critically reviewed by de Langen,[6] who also gives a detailed account of one case. He remarks that the absence of carefully-observed cases is probably due to the fact that the glycosuria is usually slight, and patients are thus seldom admitted to hospitals. In his own case, a neurasthenic young man of 20 years of age, with a neuropathic family history, the amount of sugar was, within wide limits, entirely uninfluenced by diet. The glycæmia was uniformly low, and also independent of the sugar intake. In the period of more than twelve months during which he was under observation, the general condition improved considerably, but the glycosuria and sugar tolerance remained practically uninfluenced.

Diabetic coma. The theories as to the causation of diabetic coma have recently been summarised as follows :[7] Klemperer and von Noorden thought that both coma and β-oxybutyric acid were the product of an unknown toxic agent, as they are associated in various other conditions, for example in fever and starvation ; in anæmic states and sometimes in dyspepsia acetone, diacetic acid and occasionally β-oxybutyric acid are excreted in increased amounts, and drowsiness may be present. On the other hand, the last-named product may be excreted apart from a comatose condition in uræmia and hysteria. Stadelmann and Naunyn do not consider that there is any specific action by the acetone bodies, but believe that the coma is merely due to the elimination of sodium bases. While admitting that the acetone bodies act specially on the vasomotor, respiratory and higher cortical centres, Nasel does not believe that a true acid intoxication occurs, such as is found, for instance, in narcosis where the hydrogen ions are really in excess in the blood. Patients with a pronounced degree of the so-called " acidosis " have the same concentration of hydroxyl ions in their blood as normal individuals, and some gouty people have a less concentration than diabetics. Hence the occasional deficiency in the latter must be merely a secondary effect of disturbed metabolism.

Blum[8] has investigated the relationship between coma and blood-pressure, and finds that the latter varies. At the beginning it is frequently normal, and then usually falls, but may occasionally rise in the course of the attack. Hypotonia of the medullary centres is usually a late symptom ; it does not depend on the height of the blood-pressure, and is apparently due to changes in the content of the tissues in water and salts.

Both clinically and experimentally it can be shown that the hypotonia is not a specific symptom of diabetic coma or the action of the acetone bodies.

Diabetes insipidus. Römer[9] has reported a case of this disease in a child aged 9 years, in which Aubing's colloid extract of the pituitary gland of the ox was administered and followed within a few hours by decreased secretion of urine, and partial disappearance of the comatose state which had previously existed. The child, however, died, and was found to have a tumour which compressed the posterior lobe and the infundibulum. He also performed certain experiments on rabbits, which showed that this extract caused diminished flow of urine. Pituitrin and Pituglandol, somewhat similar preparations, had the same effect though in less marked degree. He therefore agrees with von den Velden and Farmi that diabetes insipidus is in some cases due to deficient pituitary secretion.

Camus and Roussy,[10] on the other hand, as the result of operative procedures on animals (dogs), have shown that the destruction of an area at the base of the brain close to the infundibulum will produce polyuria when the latter structure itself is intact. Removal of the hypophysis alone did not produce polyuria.

J. M. FORTESCUE-BRICKDALE.

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[6] Abstract in *Schmidt's Jahrbuch*, 1914, cccxix. 570.
[7] *Med. Rec.*, 1914, lxxxv. 204.
[8] *Berl. Klin. Wchnschr.*, 1913, l. 2135.
[9] *Deutsche. Med. Wchnschr.*, 1914, xl. 108.
[10] *Compt. Rend. Soc. de Biol.*, 1914; abstract in *Lancet*, 1914, ii. 513.

SURGERY.

Fracture of the Neck of the Femur.—The unsatisfactory nature of the results of intra-capsular fracture of the femur, especially in old people, is well known. Royal Whitman[1] maintains that repair is possible in every variety of this fracture, provided the fragments are in contact. The object of treatment, therefore, is to provide opportunity for repair, and he claims that the abduction treatment is the only method that enforces

[1] *Ann. Surg.*, 1914, lx. 262, 485, *et seq.*

this principle. Whitman's method, which is not sufficiently well known, is carried out as follows in cases of complete fracture: The patient, generally under an anæsthetic, is lifted to a pelvic support, preferably furnished with a perinæal bar for counter-pressure. The extended limbs are supported by assistants. The assistant holding the uninjured limb abducts it to the normal limit in order that it may serve as a guide and to fix the pelvis. The injured limb is first flexed and rotated sufficiently to disengage any soft parts that may be interposed between the fragments. It is then completely extended, and the assistant by pulling on the limb, overcomes the shortening as demonstrated by measurement, and by the relation of the tip of the great trochanter to Nélaton's line, and at the same time corrects the outward rotation. Still maintaining steady traction, the limb is then abducted by the assistant to correspond with its fellow, the operator meanwhile supporting the joint and lifting the thigh upwards. The pelvis should now be level, and the extended limbs in exact correspondence. A plaster of Paris spica is then applied from the axilla to the toes on the affected side, careful adjustment being made about the pelvis and trochanter. It should completely cover the buttock, and be heavily reinforced beneath the joint and thigh so that it may be effective in holding the limb in its proper place. The complete reduction of the shortening is essential to the success of the method. The limb is lifted because it is often below its proper relation to the trunk. The reason for complete abduction is that in this position the upper end of the lower fragment is turned to meet the lower end of the upper fragment, and as the capsule becomes tense, it directs them towards each other, and finally forces them into contact. The tense capsule acts as an antero-posterior splint, and upward displacement is prevented by the engagement of the outer fragment with the rim of the acetabulum if the fracture is near the head, or by direct contact of the trochanter with the side of the pelvis it it be at the base.

In incomplete or impacted fractures the deformity can be corrected in nearly all cases in the manner described, aided by gentle downward pressure on the trochanter. There is a type of incomplete fracture, however, in which the neck is depressed by the opening of a wedge-shaped interval in its upper border, and in which the deformity is corrected by traction and abduction.

No direct pressure should be permitted for many months, nor until voluntary control has been regained, and until passive movements are relatively free and painless. The most usual misconception of the abduction treatment is that it requires force; but, practically speaking, no force is required in the cases now under consideration.

Whitman asserts that, as compared with other methods, the abduction treatment is not only efficient, but it has a far wider range of application. The plaster spica being an independent splint, permits any desired change of posture; and the head of the bed may be elevated in order to lessen the danger of internal congestion, and to increase the blood supply of the injured bone. Pain on movement, bedsores and hypostatic congestion are, therefore, practically eliminated as complications.

The most important and reasonable explanation of failure of union by ordinary treatment is low vitality resulting in an incapacity for repair; and this is also the most forcible argument for accurate and secure adjustment of the fractured surfaces in order to assure the possibility of union.

In discussing Whitman's method Hotchkiss [1] stated that since adopting the abduction method of treatment his results had been distinctly better. By this method, function is restored and union secured, and in many instances the results were unexpectedly gratifying. Hitzrot [2] has found this method extremely satisfactory in those cases involving the narrow part of the neck, but not involving the trochanter. In some of the latter cases he considers that the results of forced abduction were not always satisfactory. Dr. Dawbarn [3] thinks that in recent cases of fracture of the neck of the femur, while exudate of callus is still possible, the method of Whitman is ideal; but in late cases, in which the period of exudation has long gone by, he prefers to expose the joint, bring the fragments into apposition, and hold them together by driving an aluminium spike through the neck and into the head of the femur. To excite an exudation of callus, he makes an injection of the glycerite of tannin, which he has found the most efficacious of all plans.

JAMES SWAIN.

OPHTHALMOLOGY.

West's operation for complete lachrymal obstruction (Hall's modification). Graham and Paton [4] showed two cases illustrating this operation, which consists of the removal of a small circular piece of mucous membrane from the outer wall of the nasal fossa opposite the anterior end of the middle turbinal. Next a rectangular flap of the mucous membrane including this hole is dissected up and turned backwards and upwards so as to lay bare the bony wall opposite the lachrymal sac. The bony wall of the sac is then chiselled away and a probe is passed into

[1] *Ibid.*, p. 508. [2] *Ibid.*, p. 509. [3] *Ibid.*
[4] *Tr. Ophth. Soc. Lond.*, 1914, xxxiv. 102.

the tear-sac through the lower canaliculus, so as to push the mucous membrane lining its inner wall through the hole in the bone. The bulging membrane is then snipped away, and the flap of nasal mucous membrane is replaced so that the holes in the sac-wall, the bone and the nasal mucous membrane coincide. A strand of strong gut or a piece of thin lead wire is passed from the lower canaliculus through the new passage and out through the nose to help to keep the flap in position and the holes in alignment while healing takes place.

The great advantage of the operation is that the canaliculus drainage system is left intact, and of course there is no disfigurement. With a narrow nasal fossa, as from a deviated septum, the operation presents considerable difficulty. The results are said to be permanent.

Cysts in the anterior chamber arising from the pars ciliaris retinæ. Holmes Spicer described a case of this very rare condition at a recent meeting of the Royal Society of Medicine. A white spot appeared at the edge of the pupil of a child aged 3 months. At 16 months there were three finger-shaped masses protruding from behind the iris into the pupillary area. Four years later these had disappeared, and a cyst about 4 mm. diameter was floating freely in the anterior chamber. Some of these cysts disappeared and fresh ones formed. When the child was shown some eight months ago there were seven cysts looking like bubbles in the anterior chamber. Ultimately the eye became glaucomatous and was excised.

Pathological examination showed that these cysts originated from the pars ciliaris retinæ. A membrane grew over the ciliary body and the back of the iris, and from the surface of this membrane the cysts grew. One of the most interesting features of these cysts is that they consisted of embryonic retinal tissue *and contained vitreous*, thus supporting the view that the vitreous is derived from the neural epiblast, and is not of mesoblastic origin.

Ethyl-hydrocuprein has recently been recommended for corneal ulcers, more particularly for those due to pneumococcal infection. Schur, of Tübingen, has had very good results.[1] At first he used instillations of a one per cent. solution, as well as direct application of the solution to the ulcer, but later he omitted the drops and applied a one or two per cent. solution to the ulcer by means of cotton wool on a probe. He keeps the cotton wool applied to the ulcer for from one to four minutes, until the cornea round the ulcer shows slight opacity. A two per cent. solution has a caustic effect upon the conjunctiva. Solutions can be sterilised without loss of activity, but act best when freshly prepared.

[1] *Ophthalmoscope*, 1914, xii. 314.

The efficiency of the eye under different systems of lighting. Ferree[1] investigated (1) the lighting conditions that give the best visual efficiency; (2) the conditions best for continued work; (3) the most comfortable conditions. Three or four hours' work in daylight causes no appreciable loss in visual efficiency. With direct artificial lighting he finds that there is a great loss, and that even with the same degree of illumination, daylight gives far better acuity of vision than direct artificial light. Proper distribution of light and surface brightness (*i.e.* diffusion of light) are of fundamental importance for sustained efficiency. Momentary judgment is misleading; too bright illumination gives a high degree of acuity, with rapid loss of efficiency and subsequent discomfort. Somewhere about 2.2 foot-candles at the point of work is best, but with proper distribution and diffusion of light the retina readily adapts itself to various degrees of illumination. Speaking of conditions obtaining in America, he says, "For the kind of distribution effects given by the majority of our lighting systems . . . . too much light is being used for the comfort and welfare of the eye." Under similar conditions the white light of the metal filament lamp is better than the yellow light from carbon filaments, both as regards acuity and maintenance of efficiency. He attributes the reputed comfort of an oil lamp to its relatively low degree of illumination and not to the quality of the light.

The question of sustained efficiency of vision is of such immense importance that further investigation ought to be conducted with a view to finding the best conditions of artificial illumination.

The treatment of the earlier stages of senile cataract. Colonel Henry Smith, I.M.S., the introducer of the operation for the removal of a cataract in its capsule, thinks that many cases of early cataract are amenable to "treatment."[2] He specially calls attention to the fact that his conclusions are the result of experience in India, where senile cataract is excessively frequent, appears at an earlier age, and matures more rapidly than in Europe.

In uncomplicated cases, with the vision reduced to about $\frac{6}{12}$ or $\frac{6}{9}$ as a result of sand-like opacities and striæ, he gives a sub-conjunctival injection of 25 minims of a 1 in 4,000 to 1 in 6,000 solution of cyanide of mercury. The younger the patient the stronger the solution needed to produce the standard reaction. The operation is done under cocaine, and is usually followed by much pain, so a hypodermic of morphia up to half a grain is given one hour previously. Within a month the patient's vision is restored to $\frac{6}{6}$ or even $\frac{6}{5}$. In the case of railway officials under his care, he gives them a month's leave and an injection of

[1] *Ophthalmology*, 1914, x. 660. [2] *Ophthalmoscope*, 1914, xii. 546.

cyanide of mercury, and they are able to resume work at the end of the month. After more than a year's experience of this treatment he has come to regard the results as permanent.

This procedure has been very little adopted by others at present. Some few are using the method advocated by Dor of Lyons, who for some ten years has been recommending eye-baths of iodide of calcium for twenty to thirty minutes daily.

Smith offers the suggestion that the remote cause of cataract in the Punjab is connected with the dietary. The prevalence of stone in the bladder covers roughly the same area as cataract. He points out that this is a grain-eating and not a rice-eating district.

The use of salvarsan in ophthalmic practice. In the *Proceedings of the Royal Society of Medicine*[1] there is a very full account of a discussion opened by Lang. Besides being of use in practically all syphilitic affections of the eye, salvarsan has proved of great use in many cases of iridocyclitis, more particularly if of sympathetic origin. It also appears to have been of some definite use in cases of late infection after cataract extraction. It is of interest also to read of a pack of foxhounds in Madras being injected with "606." By being so treated they were saved from a form of piroplasmosis (conveyed to the hounds by an infected tick), which in previous years had carried off practically every hound in the pack.

C. H. WALKER.

Reviews of Books.

Nietzsche. By J. M. KENNEDY. Pp. 192. London: T. Werner Laurie, Ltd. 1914. 1s. net.

Nietzsche was a German, a bit of a genius, and a crank, who finished up, appropriately enough, as a lunatic. The German nation, whose religion he described as at best a lifeless Lutheranism, and at worst a pernicious hypocrisy, is believed in England, just at present (1914), to have abandoned that religion at his request, and taken his works as gospel and *vade mecum*. This is one of those beliefs that flourish because of their rank absurdity. Nietzsche was disgruntled, hipped and gravelled with his German surroundings and everything German. He gave his fellow-countrymen the greatest scourging any nation has received since the days of the Prophet Jeremiah. But his philosophy has no coherence, and a German who said,

[1] 1913–14, vii., *Ophth. Sect.*, p. 75.

"I believe in Nietzsche," might as well say, "I believe in Edward Lear's collected Nonsense Works." Possibly the Germans are being persuaded that the British Empire believes the teachings of G. B. Shaw, in which case they are making the same mistake about Shaw that we make about Nietzsche. "Develop yourself and don't be a slave," is the most useful part of his advice to the world. He wanted to see a Europe imbued with this doctrine, and scraped clean from the barnacles of culture in which Germany is so prolific. He could not predict where the lead would come from—it would need men and supermen—but certainly, of all nations, it would never come from the Germans, men who reached the limit of pack-hound servility.

The disastrous consequences of too much learning were known to the "most noble Festus," and even earlier observers. That was before science had begun to unpack her stores, and while yet history was a happy field for flowers of the imagination. It was not too much learning that drove Nietzsche into an asylum—he has some penetrating shafts to fling at learned pedantry—but too much brooding. No doubt the portion of our planet labelled German Empire is full of people "gey ill to live with," but Nietzsche's real quarrel was with the planet at large, and, in the last analysis, with himself. As a rule, if a man cannot be comfortable where he is he cannot be comfortable anywhere.

Nietzsche got hold of certain principles, "survival of the fittest" in the main, which were in the air at the time, and worked them to the bitter end. Perhaps Darwin came near to surprising one of Nature's secrets, but the German wanted to go farther, and imagined man could use this secret in his own way for his own purposes, leaving Nature to echo the lament, "Othello's occupation's gone." Folk-lore is strewn with parables hinting at the deadly danger of this attempt—the Sphinx, Bluebeard's Cupboard, and the Tree of Knowledge. "Glissez, mortels, n'appuyez pas," should be the motto of a philosopher who wishes to retain his digestion, sanity and content. Even for the man of genius a bath in the commonplace, among commonplace people, including so-called fools, is a wholesome antiseptic and tonic. Truth is so many-sided, that any single side of it, especially one's own, is bound to be false. Nietzsche exposed the tender parts of his skin, perversely, to the prickles of life; more sensible people delegate the duty of encountering prickles to the indurated portions of their epidermiz.

Nietzsche exhibits, however, the characteristics which Germans have copied with such assiduity and success, that they permeate apparently the whole nation—swelled head, hardening of the heart, and softening of the brain. The frog tries to become the ox, and declares a world war; or, even more pathetic, tries to become a butterfly and coin epigrams, at

which game the French easily fly over him. Confronted by a rainbow, and incapable of rejoicing in its beauty, the super-German will chop it up and reduce it to hideousness. It is a queer taste and trade, as if a sausage maker should boast of converting good meat into a cylinder of superlative nauseabundity.

Mr. Kennedy's selection is judiciously compiled. If the reader is immune from attacks of philosophico-melancholia he can turn to Nietzsche as to a quarry of arresting thoughts, some of which come as near to being epigrams as anything of German utterance. Without any delicacy, humour or wit, his sentences have relief. He stands at work like a wild stone-mason (the cover of the book has a good portrait of him, with hair and features of palæolithic man, and eyes of a wolf trapped in a cave). Such an artist is bound to attract a crowd as soon as the cry is passed along: "Hi, boys, come and see him make the chips fly!" He is nothing like as original as he fiercely claims to be. Thus the theory of the recurrent world-cycle is older than Virgil, but he is daring and destructive, and readers of this shilling book, if they did their borrowings with discretion, would be able to pose as regenerators of society, to the great discomfiture of the common herd.

Arteriosclerosis: a consideration of the Prolongation of Life and Efficiency after Forty. By LOUIS FAUGERES BISHOP, A.M., M.D. Pp. x, 383. London: Oxford Medical Publications. 1914. Price 10s. 6d.

"Arteriosclerosis is much more frequent than formerly." We prefer to say that the diagnosis of the disease has been far more frequent than formerly, especially in America, and that it has been founded far more on obscure clinical data than on the evidence of the pathological laboratory. Fifty years ago much was written on arterial hypertrophy, and a lengthy controversy took place between Sir John Simon and Sir George Johnson, in which Dr. Howship Dickinson afterwards took a leading part, as to the question whether the hypertrophy was physiological or pathological. It will now be generally admitted that both causes are concerned in it, and that the physiological evidence derived from the introduction of the various forms of blood-pressure gauges has been of far more importance in the establishment of the modern views enunciated in this book than the *post-mortem* study of the arteries themselves.

The causes and the natural history of the condition are dealt with in considerable detail, and some excellent drawings of the arteries, as they should be in accordance with the author's

views, showing hypertrophy of the media and sclerosis with the same modified by hypertonicity, which seem almost too precise to have been drawn from actual specimens, even when prepared in a similar way. There must be many fallacies in specimens of this kind, depending on the mode of preparation, as there are also in the clinical evidences drawn from the various forms of sphygmometer. The many polygraphic tracings in the book are not so convincing as the originals are likely to have been, and the skiagraphs of heart and aorta are open to various interpretations other than the diagnosis of arteriosclerosis. Questions of diet are fully considered, and the author's belief is that most cases of cardio-vascular disease developing past middle life are instances of chronic food poisoning. The best method of detoxication is by serial doses of castor oil—three doses of one ounce at forty-eight hours' intervals. He insists strongly on a low protein diet, limiting the protein content of the food to fifty grams daily (equivalent to a single chop). He points out that the high protein diet of the American people is largely responsible for a world of mischief, the real cause of which has not been generally understood or even suspected until recently, and he emphasises the value of cheese as one of the chief articles of diet for the supply of the protein element. He enters fully into questions relating to the chemistry of the proteins, and quotes the opinions of American physicians in support of his views, which are largely in agreement with those of our uric acid specialist, Dr. Haig. The book is one which should be carefully studied, and it cannot fail to be of great utility in the dietetic and general management of those whose mode of life tends to the production of this widespread and far-reaching malady.

Gas Poisoning in Mining and other Industries. By JOHN GLAISTER, M.D., D.P.H., F.R.C.S.E., etc., and DAVID DALE LOGAN, M.D., D.P.H. Pp. xi. 471. Edinburgh: E. & S. Livingstone. 1914. 10s. 6d. net.

At last we have a reasonably complete account of the voluminous literature in recent years upon the subject of carbon monoxide poisoning, a subject which has become of great importance owing to the immense increase in the use of "producer gas," and gas engines in place of steam, and to other industrial changes. The traveller by night through the Black Country no longer sees pillars of fire from the blast furnaces, for the gas is now covered in and carried off to drive the engines and even to work the mines. Unfortunately the furnace gas

which contains perhaps 30 per cent. of CO, has a disastrous tendency to leak through tubes, earth, and even brickwork, with often fatal results. In mines the fire-damp, CH_4, and the black or choke-damp are in themselves chiefly harmful through the absence of oxygen; but explosions, fires, and blasting produce after-damp and white or sweet-damp, containing large quantities of the deadly carbon monoxide. It is curious that there should have been so much discussion as to whether this gas is poisonous in itself or merely from its excluding oxygen, for there can be little doubt of its intrinsic harmfulness when we consider its peculiar effect on respiration, so different from that of CO_2 and similar bodies, and the hemorrhages it causes in the brain and cord. The author describes at length the remarkable group of symptoms to which it gives rise, especially the sudden loss of muscular power, the heart failure, the neuritis, the bulbar and other nervous affections. Beside the central paralyses there are frequently peripheral ones, which are rarely symmetrical and most often right-sided. Trophic and vaso-motor changes may occur without loss of motor power and sensation, or *vice versa*. As to treatment, we are warned of the necessity of forbidding exertion and maintaining body warmth, of keeping up artificial respiration for long periods, and of administering oxygen by a mask under some pressure. In a few cases venesection may be useful, as well as saline injections and transfusions.

A very full abstract is given of Mott's invaluable paper on "The Pathology of CO Poisoning," and a bibliography extending over eleven pages.

The arrangement of the material is perhaps hardly as clear as might be wished, but the wealth of detail collected from English and foreign sources is so great that one cannot be surprised. The book is of great value not only on its scientific side, but also for sanitary work and in connection with compensation cases.

A Text-Book of Insanity and other Mental Disorders. By CHARLES ARTHUR MERCIER, M.D. Second Edition. Pp. viii. 348. London: George Allen and Unwin, Ltd. 1914.

If Dr. Mercier is critical of the work of others, he is punctilious in the preparation of his own; accordingly, he is careful to previse the purposes and limitations of this book, so that within these only is criticism appropriate. It is set out for the student and practitioner (and fulfils this intent far better than

most manuals so prefaced), but it is also designed to profit the alienist, whom one might suppose from sundry observations is still rather benighted amongst the mists of a vague psychology. We consider this book quite an ideal one for the student, and a valuable one for the alienist. There has been a long series of text-books issued on insanity, some excellent in their kind, some redeemed by individual researches, others which in the words of scripture had better have never been born. Those issued specially for the student, according to the scheme of the publisher, have mostly been treated in stereotyped manner; for this examiners have been largely responsible. Each succeeding work seeks to cover a larger ground; there is necessarily inadequate, and in relation to the beginner, unprofitable, summary of anatomy, physiology, pathology, experimental and other psychology. Most of this, as Dr. Mercier indicates, is superfluous under the circumstances. He has therefore discarded the majority of these encumbrances, and has adopted and elaborated a scheme of which the germ is to be found in the older treatises, that is the constitution of mind in its various faculties; an eminently practical mode of regard. These faculties have, however, for the first time been sifted, grouped, and stratified in their order of evolution, and the result is a singularly clear exposition of normal mind which the student can at once grasp, and of whose parts the relationships can be estimated. This plan having been established, disordered states can be arranged in an equally lucid manner; and here one may comment on the ingenious way in which the clinical aspect of insanity has been treated *pari passu* with morbid psychology, so that its general features are elucidated before a single chapter has been devoted to any form or kind of mental disorder. The section on "Classification" is beyond mere theoretical importance, dealing as it does with the distinctions between primary and derived insanity, which must be seized in forming estimate of any case.

Pathology is not treated to any extent. This we think is wise. The description of the morbid anatomy of general paralysis is, however, excellent. Other sections of the book deal with lunacy law and criminal responsibility.

Dr. Mercier's definition of paranoia appears to correspond to hallucinatory delirium so-called, whilst the ordinary significance, we believe, answers to the "délire d'interpretation." To this latter Mercier's delirium of exaltation or abasement seemingly corresponds. This is the second edition, and should be by no means the last. Let us, in conclusion, express our gratitude to Dr. Mercier that he has excluded that veritable "King Charles's head" of modern text-books, dementia precox, as also manic-depressive insanity!

Tabular Diagnosis: An Aid to the Rapid Differential Diagnosis of Diseases. By RALPH WINNINGTON LEFTWICH, M.D. Pp. vi, 359. London: Edward Arnold. 1913. Price, 7s. 6d. net.—There is a singular difficulty in deciding how far a method of memorisation is in itself good or bad. Some memories, no doubt, are best served by bare lists of words which are apparently photographed into the mind. This work provides an example of such a method carried to a great degree of perfection. A collection of 350 diseases or symptom-complexes reduced each to some ten or twelve salient points is put together, so that pairs of diseases may be rapidly contrasted according to the table of their symptoms. This method fails in the actualities of life, and for this reason, that, for example, "cerebellar tumour" is contrasted only with "ataxic paraplegia," with "hereditary cerebellar ataxia," and with "cerebral tumour"; while another and more difficult task may be to distinguish the condition from mere "labyrinthine" disease. We have found that practitioners who rely upon this class of book are apt to make artificial difficulties based upon the tables they have learnt, to overlook any unforeseen similarity of diseases, and to remain wholly unobservant of unusual symptoms not included in their stereotyped lists and charts. They tend to trust to dead reckoning, and forget to "heave the lead" when in a fog. But the book is well arranged and well printed.

Medical Electricity. By H. LEWIS JONES, M.A., M.D. Sixth Edition. Pp. xv, 551. London: H. K. Lewis. 1913. Price, 12s. 6d. net.—Dr. Lewis Jones's *Medical Electricity* is by now the established hand-book in English on this subject. This the latest edition serves to emphasise the fact. The author must feel some satisfaction at the firmer foundation upon which electro-therapeutics now stands. To this he has himself largely contributed by his happy combination of scientific knowledge, clinical acumen and literary elegance.

The Clinical Pathology of Syphilis and Parasyphilis, and its Value for Diagnosis and Controlling Treatment. By HUGH WANSEY BAYLY, M.A., M.R.C.S., L.R.C.P. Pp. xiii, 194. London: Baillière, Tindall & Cox. 1912. Price, 5s. net.—The author, who is pathologist to the London Lock Hospital, has written an excellent little manual which will prove of the greatest assistance to the clinician. The modern developments in the diagnosis of syphilis are not sufficiently widely known or understood, nor is their importance adequately insisted upon by those responsible for the instruction and examination of students. We recommend this book as being a short and intelligible explanation of the technique of simple clinical

pathology and its bearing upon the diagnosis and treatment of syphilis.

Our Outsides, and what they Betoken. A Summary by W. T. FERNIE, M.D. Pp. xi, 407. Bristol: John Wright and Sons Ltd. 1913. Price, 4s. 6d.—Dr. Fernie bids fair to rival the immortal anatomist of melancholy in his merry and facete writings. Hitherto it has been possible in a review to convey some hint of the contents of one of his books. Now, however, we confess to defeat. Temperaments, physiognomy, phrenology, manners and fashions, clothes and complexions, form the burden of this volume. But to analyse and explain how it comes to form such pleasant reading would be like inquring what goes into *Bouilla baisse*. In Anthony Wood's words, "'Tis a book so full of variety of reading, that gentlemen who have lost their time and are put to a push for invention, may furnish themselves with matter for common or scholastical discourse and writing."

Diseases of the Heart. By JAMES MACKENZIE, M.D., F.R.C.P. Pp. xxiii, 502. London: Oxford Medical Publications. 1913. Price, 25s. net.—The main changes in the third edition of this work lie in the illustrations derived from electrocardiograms. The correlation of *post-mortem* investigations with clinical observations made under modern conditions has enabled the author to throw additional light upon obscure cardiac symptoms and syndromes. Each new edition of Mackenzie on the Heart is beginning to be looked for with eager interest.

Lectures on Medical Electricity to Nurses. By J. DELPRATT HARRIS, M.D. Durh., M.R.C.S. Pp. ix, 88. London: H. K. Lewis. 1913. Price, 2s. 6d. net.—For an elementary course of instruction illustrated by practical demonstration this book is well planned. It is doubtful whether the mere reading of it by any nurse would add anything to her knowledge of the subject, unless she had attended some practical classes. Certainly, after the rudiments of electricity have been mastered, much assistance could be obtained from these lectures. The practical hints called "useful wrinkles" at the end of the book are sound and well expressed. The price is moderate, and the printing and illustrations are good

Natural Therapy: a Manual of Physiotherapeutics and Climatology, By THOMAS D. LUKE, M.D., F.R.C.S. Edin., and NORMAN HAY FORBES, F.R.C.S. Edin., and F.R.S. Edin.. Pp. xvi, 316. Bristol: John Wright & Sons Ltd. 1913. Price 5s. net.—We are glad to see a second edition of this interesting introduction to physical therapeutics. The claims

of hydrotherapy, thermotherapy, and other natural agents are put forward with reason and moderation, and the criticism of opponents is not forgotten. We may give as instances of this fairness the accounts of the Nauheim Baths and of High Frequency Currents. The relation of cutaneous areas to internal organs by vascular as well as nerve reflexes appears rather peculiar. But the authors give a vivid and useful account of the methods used in the large hydropathic and thermal establishments, methods which have been found successful, and of which most of us are profoundly ignorant. A new feature in this edition is a chapter on climatology from the pen of Dr. Forbes, packed with common-sense suggestions as to the choice of climates and watering-places for invalids. In a small volume such as this omissions must be expected, but a valuable bibliography of each subject shows where detailed information should be sought for. One would have thought, however, that space would have been found for a fuller account of the cold bath treatment in fevers, where hydrotherapists have scored their greatest triumph. A section on ionization might well have replaced much of the space taken up by descriptions of electric batteries, and we should like a clearer statement of the necessity when working with currents from the main of always employing a secondary current, or one from a motor transformer, even for local baths. It is so easy even in a private house to pass a sinusoidal lighting current through a sledge coil and lamp, and thus get a safe and pleasant electric bath. One of the best and most interesting sections in the book is the discussion on the relative values of luminous and non-luminous heat and their physiological effects. In the chapters on diet it is curious to find cropping up the unfounded preference for toast over bread in mild cases of diabetes, and the absence of the Lenhartz diet in gastric ulcer. The authors have certainly succeeded in giving a large amount of information in a manner calculated to awaken much interest in their subject.

The Fæces of Children and Adults. By P. J. CAMMIDGE, M.D. Pp. viii, 516. Bristol: John Wright & Sons Ltd. 1914. 17s. 6d. net.—This book contains an account of the methods of microscopical, bacteriological and chemical examinations of the fæces, together with a consideration of the diagnostic value of such work, and some indications for treatment. The index is very thorough, and there is a useful appendix giving various forms of dietaries. The author states that the book is chiefly a compilation from Hecht's "*Die Fæces des Sauglings und des Kindes*," and Schmidt and Strasburger's "*Fæces des Menschen*." Dr. Cammidge has, however, added some observations of his own. Each chapter has its own bibliography. The volume will be found useful for reference, but it has not been written

in a manner particularly helpful to the laboratory worker. Perhaps this will be remedied in a future edition. The illustrations are a little crude in colour and design, and it is a question whether they will be of much value to the student or practitioner. Although we are not quite in accord with the form in which this book is cast, we recognise the evident care in preparation, and the value of the record of details. There will be many a tribute of thanks for the unsparing energy and thought which has resulted in the publication of an English book of reference on this subject. Very probably, however, the author will himself admit that the whole subject is being extended unnecessarily, and that he has been compelled to submit a compilation of a large number of comparatively isolated facts, difficult to digest, and almost beyond the powers of memory. Some chapters containing a critical survey of methods and observations, and a short résumé of the more general principles concerned might have been added with advantage.

Thomas Shortt. By ARNOLD CHAPLIN, M.D. Pp. 70. London: Stanley Paul & Co. 1914. Price 2s.—The author of *The Illness and Death of Napoleon*, now gives us a history of the principal medical officer in St. Helena, with biographies of some other medical men associated with the case of Napoleon from 1815 to 1821. We have no wish to re-open the unseemly controversy surrounding the illness and death of the first Napoleon, but the fact that Dr. Shortt was in 1820 appointed as Principal Medical Officer to the King's Forces in St. Helena brought him into the controversy, and formed the most notable event in his military career. He was in charge of the proceedings at the *post-mortem* examination, and the following statement made by him shows how immaterial was the controverted question as to some enlargement of the liver. He wrote: "In opening the body it presented an unusual quantity of fat, and every part of it was sound, excepting the stomach, which was a perfect mass of disease from cancer, and ulcerated in several places. In one place near the lower opening there was a hole sufficiently large to admit the little finger, which penetrated the coats of the stomach, and which was attached to the liver so that the contents were prevented from escaping." Shortt appears to have been unjustly criticised, for his only crime was that he had the courage to state what he honestly believed, and not what the official minds desired. After leaving St. Helena in 1821 Dr. Shortt resumed his practice in Edinburgh, where he became a physician of considerable note. In 1842 he became Inspector of Prisons in Great Britain, but was attacked with pneumonia in 1843, and died in the fifty-fifth year of his age.

Editorial Notes.

Consulting Surgeon, Southern Command.

Professor James Swain, M.D., M.S. Lond., Senior Surgeon, Bristol Royal Infirmary, has been appointed by the War Office as Consulting Surgeon to the troops serving in the Southern Command, with the rank of Lieutenant-Colonel. The duty involves Colonel Swain holding himself in readiness for consultation in cases of especial difficulty over the South and West of England, comprising the area west of Weymouth, Dorchester, Salisbury, and as far north as Wantage and Oxford, and with the large number of transfers from the expeditionary force, as well as the new armies now training in the Southern Command, his task can be no sinecure. We, however, feel it a legitimate cause for congratulation that the surgeon for such a very responsible office has been appointed from the Bristol School. Lt.-Col. A. E. J. Barker, F.R.C.S., R.A.M.C.T., has been appointed as Consulting Surgeon for the Eastern portion of the Southern Command. The corresponding appointments for the other commands hitherto made comprise Sir Arbuthnot Lane, Aldershot Command; Sir Frederic Eve, Eastern Command; Sir Charles Ball and Sir Thomas Myles, Irish Command.

* * * * *

Second Southern Hospital Ambulance Work.

The large numbers of British and Belgian wounded from the front sent for treatment at the Second Southern General Hospital have thoroughly tested the transport arrangements in connection with this Hospital, and the work has been none the lighter from the fact that this Hospital unit comprises three separate hospitals,

each lying at a distance of about three miles from the other two. Nevertheless, all difficulties have been removed by the excellent organisation of the Bristol Red Cross Society and the St. John Ambulance Brigade, the transport work of both being under the direction of one head, the Bristol Red Cross Society's County Director, John S. Griffiths, being also Deputy Commissioner in charge of the Southern and Western District of the St. John Ambulance Brigade.

One may judge of the task imposed in that the removals have averaged over one thousand patients a month since the war began. They have fourteen ambulance wagons in use, the Bristol Tramways and Carriage Company have sent many motors, and a large number of private motor cars have been freely placed at the disposal of the transport organisation. They meet all trains, and frequently these arrive between midnight and one o'clock, and in this way during the week from December 26th to January 2nd no less than 460 wounded have been met at the railway station. Here the members of the women's detachments have done good service in supplying coffee and refreshments while the medical officers and orderlies are arranging the removal from train to ambulance. The Second Southern Hospital must be warmly congratulated on the assistance to their work which has been so well afforded in this way in the silent watches of the night.

The Library of the Bristol Medico-Chirurgical Society.

NINETY-FOURTH LIST OF BOOKS.

The following books have been received since the publication of the List in September.

November 30th, 1914.

Bainbridge and J. A. Menzies, F. A. *Essentials of Physiology* 1914
Calot, F. .. .. *Indispensable Orthopædics* (Translated from 6th French Edition by A. H. Robinson and L. Nicole) 1914

Cunningham [D. J.] *Manual of Practical Anatomy* (Revised and edited by A. Robinson) Vol. II. 6th Ed. 1914
Desparé, L. L. .. *Text-book of Massage* .. .. .. 2nd Ed. 1914
Elmslie, R. C. .. *Remedial Exercises in Schools and Clinics* .. 1914
Fitzwilliams, D. C. L. *A Nursing Manual* 1914
Friel, A. R. .. .. *Obiter Scripta Throat, Nose and Ear* 1914
Gould, Sir A. P. .. *Surgical Diagnosis* .. .. 4th Ed. 1914
Goulston, A. .. .. *Cane Sugar and Heart Disease* 1914
Hayes, R. .. .. *Aachen Treatment of Syphilis* 1914
Lejars, F. .. .. *Urgent Surgery* (Translated from 7th French Edition by W. S. Dickie) Vol. I. 3rd English Ed. 1914
Menzies, F. A. Bainbridge and J. A. *Essentials of Physiology* .. 1914
Oliver, Sir T. .. *Lead Poisoning* 1914
Paton, D. N. .. .. *Essentials of Human Physiology* .. 4th Ed. 1914
Pharmacopœia, The British 1914
Quain, [J.] .. .. *Elements of Anatomy* .. Vol. II. Part II. 11th Ed. 1914
Sutherland, G. A. .. *The Heart in Early Life* 1914

TRANSACTIONS, REPORTS, JOURNALS, ETC.

American Ophthalmological Society, Transactions of the Vol. XIII. Part III. 1914
Archives of the Röntgen Ray .. .. Vol. XVIII. 1913–14
Collected Studies from the Laboratories of Health, New York Vol. VII. 1912–14
Hospital Reports, Episcopal .. .. Vol. II. 1914
Medical Officer, The .. .. Vol. XI. 1914
Ophthalmological Transactions .. .. Vol. XXXIV. 1914
Progressive Medicine .. .. Vol. III. 1914
Revue Hebdomadaire de Laryngologie .. Tom. XXXV., Vol. I. 1914
Royal Academy of Medicine in Ireland, Transactions of the Vol. XXXII. 1914
Zentralblatt für Chirurgie .. .. Bd. I. for 1914
Zentralblatt für Gynäkologie .. .. Bd. I. for 1914
Zentralblatt für innere Medizin .. .. Bd. I. for 1914

MEETINGS OF SOCIETIES.

Bristol Medico-Chirurgical Society.

Annual Meeting, October 14th, 1914.

After a vote of thanks to the retiring President, Dr. P. Watson-Williams, had been passed, Dr W. H. C. Newnham took the chair, and gave an introductory address (*see* p. 257). Later a cordial vote of thanks was given to Dr. Newnham for his able and interesting address.

The Acting Honorary Secretary, Dr. J. M. Fortescue-Brickdale, read the following annual report :—

During the year eighteen new members had been elected and fourteen had resigned. The Society had to regret the loss of one member by death. There was now a total of four honorary and 174 ordinary members.

The balance from the previous year was £98 2s. 3d., and on this year there was a balance of £14 12s. 6d.

The average attendance at meetings had been 35.

The Hon. Librarian, Mr. C. K. Rudge, then read the following report :—

The Library of the Bristol Medico-Chirurgical Society now contains 12,867 volumes. During the year 616 volumes have been added, of which 86 have been received for review in the *Journal* of the Society, and the remainder by gift or exchange. The Library is in regular receipt of 191 periodicals, 28 of which are purchased and 163 received in exchange.

During the year 754 issues of books were made to 93 members, and 28 volumes had been obtained from Lewis's Library.

The Bristol Medical Library, to which members have access, now contains 23,576 volumes, and 253 British and foreign periodicals. The number of volumes mentioned was made up in the following manner :—

BOOKS.

Bristol Medico-Chirurgical Society ..	12,867
University of Bristol	8,946*
Bristol Royal Infirmary	1,189
Bristol General Hospital	574
Total	23,576

* An increase of 164.

CURRENT PERIODICALS.

Medico-Chirurgical Society	191
University of Bristol	61
Total	252

The following are the officers of the Society for the Session 1914–15 : President—W. H. C. Newnham, M.A., M.B. Cantab. ; President-Elect—G. Parker, M.A., M.D. Cantab. Committee (*ex-officio*)—P. Watson-Williams, M.D. Lond. (Past President and Editor of *Journal*) ; C. K. Rudge, M.R.C.S. (Hon. Librarian) ; J. M. Fortescue-Brickdale, M.A., M.D. Oxon. (Editorial Secretary) ; A. J. Wright, M.B. Lond. (Hon. Secretary). (*Elected*)—R. Shingleton Smith, M.D. Lond. ; G. Munro Smith, M.D. Bristol ; I. Walker Hall, M.D. Vict. ; J. Lacy Firth, M.D. Lond. ; J. O. Symes, M.D. Lond. ; L. E. V. Every-Clayton, M.D. Lond. ; F. H. Edgeworth, M.D. Cantab. ; H. S. Ballance, M.D. Lond. Hon. Secretary—A. J. Wright, M.B. Lond. Acting Hon. Secretaries—J. A. Nixon, B.A., M.B.

Cantab. (*Financial*); J. M. Fortescue-Brickdale, M.A., M.D. Oxon. (*General*). Library Committee—C. K. Rudge, M.R.C.S.; G. Munro Smith, M.D. Bristol; W. A. Smith, M.A., M.B. Oxon.

RECEIPT AND EXPENDITURE ACCOUNT OF THE BRISTOL MEDICO-CHIRURGICAL SOCIETY, SESSION 1913-14.

	£	s.	d.		£	s.	d.
Balance from 1912–13..	98	2	4	Honorarium (Farr) ..	10	0	0
Members' Subscriptions	156	9	0	Postage	1	0	0
Interest on Deposit ..	0	19	6	Library Grant	30	0	0
				Telephone	6	10	0
				Lanterns	1	1	0
				Postage	3	0	0
				Fortt (refreshments) ..	1	19	0
				Cheque Book	0	2	6
				Meeting Expenses 11/2/14	0	17	6
				Lantern	1	1	0
				Lantern	0	15	3
				Meeting Expenses ..	0	10	0
				University Marshal ..	1	11	6
				Library Grant	50	0	0
				Trübner	0	19	7
				Journal Grants	75	0	0
				Arrowsmith	2	9	6
				Auditor	0	10	6
				Rent to University ..	52	10	0
				Petty Cash	1	1	0
				Balance in Bank	12	10	6
				Balance in hands of Acting Secretary	2	2	0
	£255	10	10		£255	10	10

November 11th, 1914.

Dr. W. H. C. NEWNHAM, President, in the Chair.

Dr. IRVING, in the absence of Dr. P. WATSON-WILLIAMS, showed a case of **Nasal Pansinusitis** in which the intersinus frontal septum had been deliberately broken down pernasally so as to assure a thorough flush through. The maxillary and sphenoidal sinuses had also been opened intranasally.—Dr. EVERY-CLAYTON spoke on the apparent advantages from breaking down the septum, and on two successful cases of which he had knowledge in which the patients had derived great benefit from the intranasal operation for frontal sinusitis.

Dr. G. MUNRO SMITH read **Notes on some of the Bristol Resurrectionists.** Drs. SHINGLETON SMITH and PARKER discussed the paper.

Dr. O. C. M. DAVIS read a paper on **The British Pharmacopœia of 1914** (Page 292). Drs. NEILD and FORTESCUE-BRICKDALE discussed the paper.

J. LACY FIRTH.
J. M. FORTESCUE-BRICKDALE,
Acting Hon. Sec.

Local Medical Notes.

University of Bristol.—Students of the University have recently passed the following examinations :—

CONJOINT EXAMINING BOARD OF ENGLAND.—*Medicine :* J. W. Gilbert, G. S. Terry, B. G. Derry. *Surgery :* Muir-Foster. *Midwifery :* W. K. A. Richards, C. N. Vaisey, H. R. W. Husbands. *Practical Pharmacy :* A. G. Morris.

LICENCE IN DENTAL SURGERY, R.C.S. ENGLAND.—*Chemistry:* B. Leathlean. *Physics :* I. Jacobs. *Mechanical Dentistry :* E. F. Vowles, S. W. A. Davis, F. L. Fox. *Dental Metallurgy :* E. F. Vowles, W. G. Milton. *Final Examination, Part I :* W. E. Drummond ; *Part II :* S. V. Shrimpton.

ROYAL NAVY.—At the recent examination of candidates for entry as Surgeons, Mr. H. B. Parker, M.B., a former Bristol student, secured first place with 2,488 marks, and was awarded the gold medal.

R.A.M.C.—B. J. L. Fayle, R. B. Johnson, R. F. Bolt, G. M. Campbell, H. J. Orr-Ewing, H. W. Goodden, R. S. Statham, C. J. D. May, C. C. Harrison, A. G. Bodman, C. Kingston.

R.A.M.C. (T.).—F. T. Boucher, H. J. D. Smythe, R. I. Dacre.

APPOINTMENTS.

Professor James Swain, M.S., M.D., has been appointed Consulting Surgeon to the Forces serving in the Southern Command, with the rank of Lieut.-Colonel, R.A.M.C.

W. A. Reynolds, M.B., Ch.B., has been appointed House Surgeon at Sheffield Royal Infirmary.

G. H. Griffiths, M.R.C.S., has been appointed House Surgeon at Cheltenham General Hospital.

J. Cecil Clayton, M.R.C.S., L.R.C.P., has been appointed Anæsthetist to the All Saints' Hospital for Genito-Urinary Diseases, Victoria ; to the Royal Ear Hospital, London ; and to Hendon Cottage Hospital.

ACKNOWLEDGMENT.

Lieut.-Col. A. W. Prichard desires to take advantage of the *Bristol Medico-Chirurgical Journal* to cordially thank those members of the profession who were asked by Dr. Devis and himself to subscribe to a present for the 3rd South Midland Field Ambulance, now mobilised for active service. Thirty shirts and a hundred and eighty long and thick mufflers were sent on November 12th, and the O.C., Lieut.-Col. Young, desired that his appreciation of the gift should be communicated to those who subscribed.

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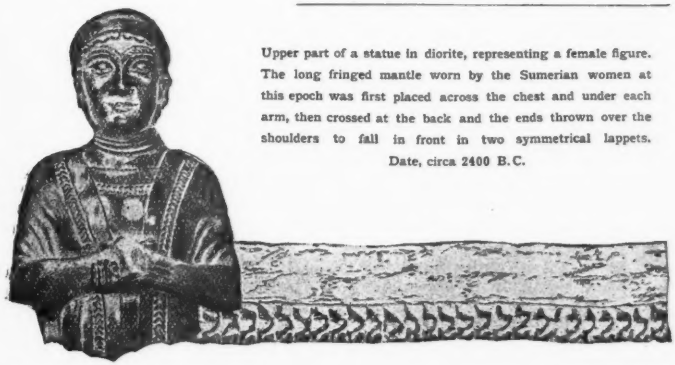

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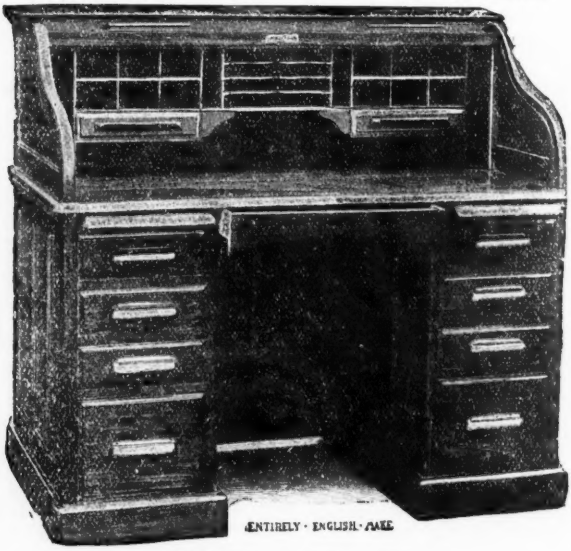

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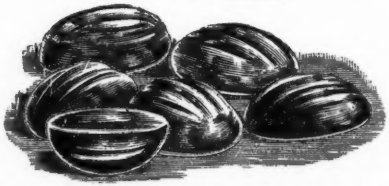

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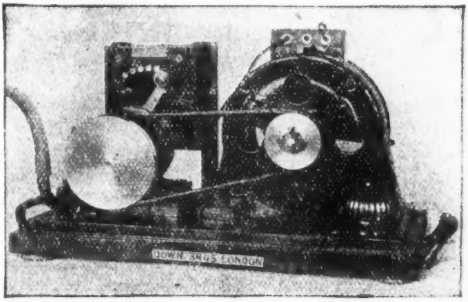

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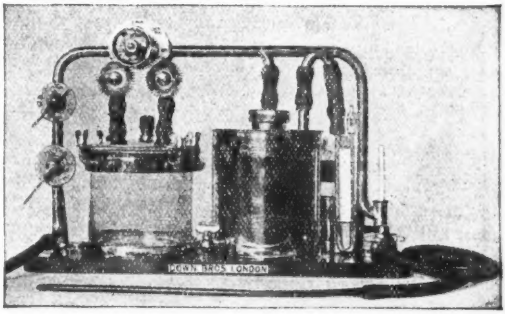

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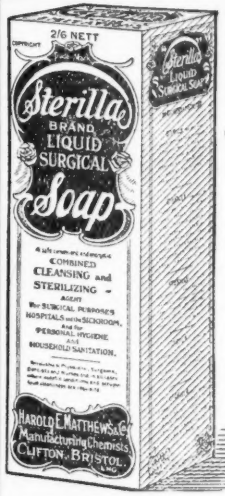

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